Introduction – information at your fingertips

Welcome to the Consultant Handbook for Scotland, online for quick access to regularly updated information and guidance. We have published this as a handy guide to the main contractual issues that may arise in your employment. It brings together an enormous amount of information, advice and guidance on many of the important issues that govern your working life. It is available 24 hours a day online for all BMA members.

This handbook applies to NHS consultants in Scotland. Although much of the information is relevant to medical academic consultants with honorary NHS contracts, they should refer to the Medical Academic Handbook produced by the BMA.

Feedback
We are happy to receive any comments on the handbook, or any suggestions on how to improve it or how to improve the services provided for consultant members. Comments should be emailed to SCC.

Whatever your question, we would suggest that this handbook is a good place to start looking for the answer. If you do need more information or help from the BMA, please don’t hesitate to get in touch. After all, we are here to support you.

To help us help you, please remember to keep your BMA membership and contact details up to date.

Contacting the BMA
The BMA is dedicated to supporting its members in virtually all aspects of their professional lives. For all your employment advice and information, please call a BMA adviser on 0300 123 1233 between 8.30am and 6.00pm, Monday to Friday except UK-wide bank holidays, or email your query anytime.

Members should always call the above number in the first instance. Your enquiry will be dealt with efficiently by our resident team of employment experts, with most queries being answered directly over the phone or by return email.

If, after contacting the above number, it is found that you need direct representation locally, you will be referred to a member of our regional services team.

Employment of consultants

NHS boards
The vast majority of consultants working in the NHS in Scotland are employed directly by NHS boards. These boards must comply with the statutory position in relation to their powers to employ staff. This means that, where pay and conditions of service for a class of NHS staff have been agreed in negotiations and approved or authorised by Scottish ministers, boards must employ such staff on those terms and conditions. Where boards want to employ staff on non-approved terms
and conditions, for example, for recruitment and retention to a specific post, then they can apply to Scottish ministers for an order allowing a variation. Subject to any variation which might be granted by ministers, all new staff must be employed on nationally approved terms, pay and conditions.

**Local and national negotiations**

UK NHS terms and conditions of service (TCS) issues are negotiated through the Joint Negotiating Committee (Seniors) (JNC). It includes representatives from the BMA (including the ), NHS Employers (the English employer body responsible for negotiations on behalf of health service employers in England), and representatives from the devolved administrations, including the Scottish Government Health and Social Care Directorates (SGHSCD) and NHS Scotland employers. There are very few genuinely UK issues left, the Working Time Regulations being the most significant.

The 2004 consultant contract in Scotland was negotiated between BMA Scotland and SGHSCD on behalf of employers and any changes to its terms and conditions must therefore be negotiated and agreed in Scotland.

The BMA has worked hard to ensure that medical staff have appropriate local negotiating machinery in NHS boards to complement the and national structures. The role of these local negotiating committees (LNCs) is to ensure that national TCS are applied, to provide a formal mechanism to negotiate any proposed changes to local contractual arrangements and to negotiate around any local flexibilities that exist in national agreements. All boards have an consisting of doctors elected by their colleagues to negotiate with management. Where LNCs have been set up according to BMA guidelines they are formally accredited by the Association. This means that they receive advice and support from BMA staff, and their members receive training in negotiating skills and are protected by trade union law.

**Consultant contracts**

The following sections deal with the contract and TCS for NHS consultants employed under the 2004 consultant contract. The pre-2004 national consultant contract is not covered, given that the vast majority of consultants in Scotland are on the 2004 contract. Consultants who remain on the old contract can obtain advice on its provisions by contacting the BMA.

**The 2004 consultant contract**

Since 1 April 2004, the ‘2004 consultant contract’ has been the only contract permissible for new NHS consultant posts, including locums. Consultants in post before 1 April 2004 had, and still have, the choice of moving on to the 2004 contract or remaining on the previous contract. Consultants working as clinical directors, medical directors, or directors of public health are covered by the 2004 contract.

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**Information**

- [2004 consultant contract](#)
The basic work commitment
The contract is based on a full-time work commitment of 10 programmed activities (PAs) per week, each having a timetabled value of four hours (or three hours if the PA is undertaken in premium time – see below). Each consultant must have a job plan that sets out the number of agreed PAs the consultant will undertake, plus a list of the duties they are expected to perform within those PAs.

A key feature of the contract is that it provides a clear maximum commitment to the NHS, including work done while on call. Any additional work above 10 PAs will be by agreement and paid at the appropriate rate. There are additional conditions applying to consultants wishing to undertake private practice.

The working week
A full-time consultant’s job plan of 10 (or more) PAs will consist of work from any of the following categories as defined in the TCS:

Direct clinical care (DCC): includes emergency duties (including emergency work carried out during or arising from on call), operating sessions, pre- and post-operative care, ward rounds, outpatient clinics, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care, administration directly related to patient care (e.g. referrals, notes, complaints, correspondence with other practitioners), on-site medical cover, any other work linked to the direct clinical care of NHS patients and travelling time associated with any of these duties. Emergency duties (both predictable and unpredictable) will be given first priority when allocating PAs for direct clinical care.

Supporting professional activities (SPA): includes continuing professional development, teaching and training, management of doctors in training, audit, job planning, appraisal, revalidation, research, contribution to service management and planning, clinical governance activities, any other supporting professional activities, and travelling time associated with these duties.

Additional responsibilities: are duties of a professional nature carried out for or on behalf of the employer or the Scottish Government, which are beyond the range of the supporting professional activities normally to be expected of a consultant. Additional responsibilities are Caldicott guardians, clinical audit leads, clinical governance leads, undergraduate and postgraduate deans, clinical tutors, regional education advisers, formal medical management responsibilities, other additional responsibilities agreed between a consultant and his/her employer which cannot reasonably be absorbed within the time available for supporting professional activities and travelling time associated with these duties. This is not an exhaustive list.
Other external duties: duties not included in any of the three foregoing definitions and not included within the definition of fee paying work or private practice, but undertaken as part of the job plan by agreement between the consultant and the employer. They comprise work not directly for the NHS employer, but relevant to and in the interests of the NHS. Examples include trade union and professional association duties, acting as an external member of a consultant appointment committee, undertaking assessments for NHS Education for Scotland, NHS Healthcare Improvement Scotland or equivalent bodies, work for the royal colleges, work for the General Medical Council (GMC) or other national bodies concerned with professional regulation, NHS disciplinary procedures, NHS appeals procedures and travelling time associated with these duties. This list of activities is not exhaustive.

It is SGHSCD policy to encourage NHS employers, as part of a corporate commitment to NHSScotland, to release consultants wherever possible for work that is not directly for the NHS employer but is relevant to and in the interest of the wider NHS and which may involve consultants being away from their employment base. Where agreement cannot be reached, the mediation or appeals processes can be used.

The job plan will set out the number of PAs for each of the different types of activities above. It will also set out the duties the consultant is expected to perform within those PAs. See the job planning section for more information on job plans.

**Balance of activities**

The contract sets out that in a 10 PA job plan for a full-time consultant, there will be 7.5 PAs of direct clinical care and 2.5 PAs of supporting professional activities *unless otherwise agreed.* There is flexibility to agree a different balance of activities. For example, if a consultant has additional responsibilities to carry out, such as being a clinical governance lead, they may reduce their DCC activities to fit this additional work into a 10 PA job. Alternatively, they may agree to undertake extra PAs in addition to the standard 10 per week. It is recognised that part-time consultants need to devote proportionately more of their time to supporting professional activities, for example, due to the need to participate in continuing professional development to the same extent as their full-time colleagues. The following table sets out the usual balance between DCC PAs and SPAs for part-time consultants.
The SCC’s position, which is supported by the UK Academy of Medical Royal Colleges, is that the vast majority of consultants, new and existing, require at least 2.5 SPAs if they have any teaching, training, research, service development, clinical governance or management responsibilities. If employers offer a different balance between DCC and SPA activities, you should refer to the SCC’s guidance on job planning [http://bma.org.uk/practical-support-at-work/contracts/job-planning](http://bma.org.uk/practical-support-at-work/contracts/job-planning).

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<th>Total number of PAs</th>
<th>Number of SPAs</th>
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<td>2 or less</td>
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<td>2.5 – 3.5</td>
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<td>6 – 7.5</td>
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<tr>
<td>8 or more</td>
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Emergency on-call work
The job plan should set out a consultant’s duties and responsibilities in respect of emergency on-call work. Under the contract, emergency work is recognised in three ways.

On-call availability supplement
Consultants on an on-call rota are paid an on-call availability supplement in addition to basic salary, which recognises the inconvenience of being on a rota and the duty to participate in it. The level of supplement depends on the rota frequency and the typical nature of the response:

- Level 1 applies to a consultant who needs to attend a place of work immediately when called, or to undertake analogous interventions (e.g. telemedicine or complex telephone consultations).
- Level 2 applies to a consultant who can attend a place of work later or respond by non-complex telephone consultations later. (It is possible for a consultant on level 2 availability supplement to agree with their employer not to be contactable immediately for short intervals, provided that there are arrangements for any messages to be taken and for the consultant to be able to respond immediately after the interval in question.)

<table>
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<tr>
<th>Frequency of rota commitment</th>
<th>Value of supplement as a percentage of full-time basic salary</th>
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<tr>
<td></td>
<td>Level 1</td>
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<tr>
<td>High frequency: 1 in 1 to 1 in 4</td>
<td>8.0%</td>
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<tr>
<td>Medium frequency: 1 in 5 to 1 in 8</td>
<td>5.0%</td>
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<tr>
<td>Low frequency: 1 in 9 or less frequent</td>
<td>3.0%</td>
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Consultants will always be paid the full value of an on-call supplement. If part-time consultants participate in the rota on the same basis and as frequently as their full-time colleagues, they will receive the same percentage supplement on their basic salary. However, if they participate in the rota on a different basis they will receive the percentage supplement that a consultant on an equivalent rota would have received. For example, if a part-time consultant was on level 1 and worked a one in 10 rota whereas their full-time colleagues worked a one in five, they would receive the low frequency supplement of 3.0 per cent: they would not get half of a 5 per cent supplement.

In calculating the frequency of the rota, it is important to take into account prospective cover rather than taking the frequency to be equivalent to the number of people taking part in the rota. Prospective cover will result in a change in the frequency of the rota commitment and therefore, of the frequency band. For example, a one in 10 or one in nine rota with prospective cover will be pushed into the medium frequency band, becoming at least a one in eight rota, and a one in five rota will be in the high frequency band, becoming a one in four rota. This is based on the formula: rota after including prospective cover is one in (number on rota x 42/52).

Information

- TCS, paragraphs 4.10.9-4.10.15

**PA allocation for emergency work**

The on-call availability supplement recognises the inconvenience of being available while on call. It does not recognise the work actually done while on call. The contract explicitly takes account of the work done by allocating an appropriate number of PAs within the weekly job plan.

For many consultants, there will be a predictable amount of emergency work arising from on-call duties (operating lists, ward rounds, administration etc). The consultant and the employer should monitor the number of hours worked over the period of the rota and calculate the average number of PAs of emergency work done per week. Prospective cover should be factored into the calculation (see below). There is no limit on the amount of predictable on-call work that can be allocated to DCC PAs.

Some emergency work will also be unpredictable and the same approach to calculating average weekly PAs spent in this type of activity should be taken. Diary evidence will be key to calculating the PA allocation fairly. Allocations for unpredictable on-call work should not exceed a maximum of two PAs per week. If unpredictable on-call work exceeds this level, this will be addressed through job planning. In exceptional circumstances, where the employer and the consultant agree that additional work beyond two PAs is necessary, this excess work will be recognised through additional arrangements locally.

The allocation of emergency PAs should be reviewed and adjusted as necessary at the annual job plan review, or whenever the consultant or the employer believes that emergency workload has changed.
Definitions of emergency work (as set out in the TCS):

**Predictable emergency work:** this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (e.g. post-take ward rounds). This should be programmed into the working week as scheduled PAs.

**Unpredictable emergency work:** this is work done while on call and associated directly with the consultant’s on-call duties (e.g. recall to hospital to operate on an emergency basis).

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**Cover for leave**
Agreement should be reached with the employer in advance through the job planning process about the circumstances in which consultants will provide cover for colleagues on leave. Any extra PAs resulting from cover will be by agreement between the consultant and employer. Where cover by consultant colleagues is not available, the employer, not the consultant, is responsible for the engagement of a locum, or other arrangement.

If a consultant covers colleagues' on-call duties when they are away on study leave, annual leave and public holidays, this prospective cover should be taken into account when assessing workload for both predictable and unpredictable emergency work. With six weeks annual leave, on average two weeks study leave and public holidays, consultants are likely to be covering nearly 10 weeks of each colleague’s duties. This may mean a consultant's average out-of-hours workload is up to 24 per cent greater in the week and 18 per cent greater at weekends than that measured when nobody is on leave. In reality, consultants can do 52 weeks of on-call work in 42 weeks at the hospital.

A consultant is under no obligation to provide prospective cover other than annual and study leave and public holidays since the extent of such a commitment cannot be predicted.

Cover for leave is an area where many LNCs have reached local agreements with employers.

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**Resident on call**
Resident on call by consultants is an extremely wasteful way of providing cover and the contract clearly states that consultants will not, save in exceptional circumstances, undertake resident on call. There is no obligation in the contract for them to do so. However in some specialties (e.g. Paediatric ICU, labour ward work), this may be necessary. LNCs will have reached a local agreement with the employer on the arrangements that will apply to consultant resident on call, including remuneration, accommodation and catering. The SCC believes that pay for resident on call should be substantially higher than standard or premium time rates.
**Duty to be contactable**

It is a requirement that while on call, the consultant must be contactable. However, it is possible for a consultant on level 2 availability supplement to agree with their employer not to be contactable immediately for short intervals, provided that there are arrangements for any messages to be taken and for the consultant to be able to respond immediately after the interval in question.

**Private practice and on-call work**

Except in an emergency, private work should not be undertaken while on call and a consultant will have to make alternative arrangements to provide cover if emergency treatment for private patients regularly impacts on NHS commitments.

**Extra PAs**

A consultant may agree with the employer to work more than the standard 10 PAs for a full-time consultant. There is no obligation on the consultant to work more than 10 PAs (but note the potential impact on pay progression below) and there is equally no obligation on the employer to offer more than 10 PAs. Where a consultant agrees to work extra PAs, these are payable at a rate of 10 per cent of basic pay, plus any discretionary points held. This is capped at eight discretionary points where a distinction award is held.

A separate contract should be agreed with the employer for any extra PAs. This should set out what work is to be done in the extra PAs; this will mean that if the consultant or the employer decides to terminate the separate contract, it will be clear what work is to be dropped.

**Private practice and extra PAs**

There is no obligation for a consultant to undertake PAs in excess of the standard 10 per week for a full-time consultant, but one of the criteria for achieving progression through seniority points is that consultants should accept an extra paid PA in the NHS, if offered, before doing private work. See the private practice section for further details.
Premium time/work done out of hours
The contract recognises work done at certain times of the week, defined as work undertaken outside of the hours of 8.00am to 8.00pm, Monday to Friday, and on public holidays, as ‘premium time’ or “out of hours work”. Non-emergency work cannot be scheduled during these times without the agreement of the consultant and there should be no detriment to pay progression or any other matter if a consultant refuses to undertake non-emergency work in premium time.

An employer cannot require a consultant to undertake scheduled work outside 8.00am to 8.00pm, Monday to Friday and 9.00am to 1.00pm on Saturdays, or on public holidays. However there are acute specialties where some “out of hours” work by consultants is necessary, so prospective appointees do need to be realistic about this possibility. If a doctor accepts a consultant post with scheduled work out of hours included in the agreed job plan (for example, on-site working overnight for three nights each month), then the doctor cannot unilaterally withdraw from undertaking this work since this would breach the contract.

The contract states that no more than 3 PAs per week should be out of hours other than in exceptional circumstances. During premium time the length of a PA is reduced to three hours (rather than four) or, by agreement, the rate of pay for a four-hour PA increases to ‘time-and-a-third’.

Location of work
It is generally expected that PAs will be undertaken at the location agreed in the job plan, which must be set out in the consultant’s individual contract. Arrangements to work off-site or at home at specified times may be agreed in relation to specified duties and should be set out in the job plan, while elements of SPA time can be scheduled flexibly and undertaken off-site.

Travelling time
Travelling time to and from the usual place of work is not regarded as working time. Travelling time between the principal place of work and other work sites is working time and should be included within the category of work (e.g. DCC, SPA) for which the journey is necessary. Travel to and from work for NHS emergencies also counts as working time.
Workload assessment

Where a consultant believes that their average workload exceeds the amount of work for which the consultant has contracted as PAs agreed in the job plan, the consultant can request an interim job plan review, which the employer will set up within one month of the request.

In such cases, the consultant will complete a diary measuring workload over an agreed period. The completed diary, along with any other appropriate supporting documentation provided by the consultant and/or the employer, will form the basis of determining the consultant’s workload. Where this demonstrates that workload does exceed contracted PAs, the job plan will be adjusted in one of the following ways:

a) the consultant and employer may agree that the consultant will continue the same level of activity and contract for a number of extra PAs which equate to the hours worked; or

b) the consultant and employer may agree a reduction in hours worked to equate to the number of PAs contracted in the previously agreed job plan; or

c) the consultant and employer may agree a combination of a) and b) so that the PAs contracted in the revised agreed job plan (including any extra PAs) equate to the consultant’s new working hours.

Where it is agreed to contract for extra PAs as in a) above, the effective date for their payment will be the date on which the consultant first brought the matter to the employer’s attention by requesting an interim job plan review. Where the employer agrees to reduce actual workload as in b) or c) above, this must be achieved within three months of the date of the interim job plan review. Time off in lieu will be accrued from the date of the interim job plan review.

If agreement cannot be reached, the mediation and appeals processes will apply.

Where an employer has concerns that the workload does not match the job plan, then they can ask the consultant to complete a diary or other supporting documentation, but if the consultant believes that this is an unreasonable request, then the consultant may refer back to the mediation and appeals processes.

Information

• TCS, section 4.6

Pay

Pay points for consultants appointed prior to 1 April 2004

For consultants appointed prior to 1 April 2004 who transferred to the 2004 contract (termed ‘existing consultants’), there are detailed pay transition arrangements set out in appendix 3 of the TCS. Basic pay depends on a consultant’s ‘seniority’. Seniority is calculated by combining completed years as a consultant with the point on the salary scale when first appointed (on a scale of 0 to 4) and then adding any additional credited seniority. Additional seniority may be given if
the consultant has any consultant-level experience gained outside the NHS, or if the consultant has undergone flexible training or dual qualification. The number of years of seniority determines the consultant’s pay point on commencement and rate of progression through the pay points. Progression through seniority and pay points becomes possible on the anniversary of the seniority date.

**Pay points for consultants appointed on or after 1 April 2004**

Consultants appointed on or after 1 April 2004 are appointed to the minimum point of the pay scale unless they have consultant-level experience gained outside the NHS or they have participated in flexible training or undergone dual qualification. Progression through seniority points for consultants appointed on or after 1 April 2004 becomes possible on the anniversary of the first seniority date.

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**Information**

- TCS, sections 5 and 14

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**Pay progression**

There are eight pay points on the salary scale. The value of the pay points is set out annually in a circular from the SGHSCD. The first five pay points are awarded at one-yearly intervals and the next three pay points are awarded at five-yearly intervals; in effect it is a 19-year pay scale. However, many existing consultants who transferred to the 2004 contract move up the scale at a different rate than this because of the arrangements agreed on transition to this contract (see above).

It is explicitly stated in the TCS that it will be the norm for consultants to progress through the seniority points unless they have demonstrably failed in any one year to:

- take part in the appraisal process, job planning and objective setting
- meet the time and service commitments in the job plan
- meet the personal objectives in the job plan
- work towards any agreed changes linked to the organisation’s service objectives
- take up an extra paid PA (if offered) if they want to work privately
- meet the contract’s private practice standards.

Employers cannot introduce any new criteria and pay progression cannot be withheld or delayed by factors outwith the control of the consultant. There is a right of appeal against any decision to withhold pay progression.

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**Information**

- TCS, section 5.2

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Waiting times initiative payments
In circumstances where, as a direct result of published national or local waiting times targets, the employer requires increased ad hoc activity not previously identified within the job plan, then the consultant and the employer can agree a separate contract for this work, which is voluntary. Such work is paid at three times the hourly rate appropriate to point 20 of the seniority scale, or alternatively, and by agreement with the employer:
• paid at twice the hourly rate appropriate to point 20 of the seniority scale set out in appendix 3 of the TCS and equivalent time off in lieu; or
• paid at the hourly rate appropriate to point 20 of the seniority scale set out in appendix 3 of the TCS and twice the equivalent time off in lieu.

Fee-paying work (appendix 5 (a) work)
Fee-paying work (formerly called category 2 work) is work that is not part of a consultant’s contractual work, but is also not classed as private practice. It includes, for example, work required for life insurance purposes and work for the procurator fiscal.

An underlying principle of the contract is that consultants should not be paid twice for the work they do. A consultant undertaking fee-paying work can keep the fee due if they are doing the work in their own time i.e. not in NHS PA time, or if they ‘time-shift’ so that their NHS work is unaffected, or if the work is, by agreement, minimally disruptive to NHS activities. LNCs have in many areas reached agreements with employers on a definition of ‘minimally disruptive’.

Fees for NHS work (section 9/appendix 5 (b) work)
Fees for NHS work, which covers domiciliary consultations, exceptional consultations, lecture fees, completion of assessment and certificate under section 47 of the Adults with Incapacity (Scotland) Act 2000, membership of consultant appointment committees and medical services to local authorities, may only be claimed if the work is undertaken outwith agreed programmed activities. Family planning is treated within the TCS as contracted work to be carried out within PAs, comprising an element of DCC work. Consultants on the 2004 contract cannot claim fees for family planning work.

Information
• TCS, section 4.3
• TCS, section 9
• NHS Circular PCS (DD) 2005/13: Amendments to the TCS for the 2004 consultant contract in respect of family planning
**Relationship between private practice, NHS work and fee-paying work**

The contract clarifies the relationship between NHS work, private work and fee-paying work. The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services and, with the exception of the need to provide emergency care, agreed NHS commitments take precedence over private work. This relationship is set out clearly in section 6 of the TCS and in the Code of conduct for private practice set out in Appendix 8 (see section on private practice for more information).

This Code has been slightly amended as a consequence of the publication of revised guidance on the arrangements for NHS patients receiving private healthcare in addition to NHS care. It allows patients to access both NHS and private care for one condition during a single visit to an NHS organisation by the removal of the first bullet point of paragraph 2.13 of the Code of Conduct.

**Recruitment and retention allowances**

In certain circumstances, employers may pay consultants a recruitment or retention premium. This can be paid as a single sum, or on a recurrent basis for a time-limited period. The value of the premium will typically not exceed 30 per cent of the normal starting salary for a consultant post. Employers are asked to consult with other NHSScotland employers about the value of any premium. To date, NHSScotland employers have agreed to operate a moratorium on the use of these premia.

**Directors of public health supplements**

Directors of public health are entitled to banded supplements (B-D and Island Health Boards) in addition to basic salary, as set out annually in SGHSCD circulars. Eligibility for each band depends upon the population served by the post and the weight of the post.
**Additional responsibility payments**

The TCS allows discretion for employers to pay additional responsibility payments. This provision can be used to pay consultants for any additional responsibilities, such as being a clinical director. Where such activities are remunerated, this will be by contracting for extra PAs or by additional remuneration agreed locally, or a combination of both. It is also possible to substitute the time for other activities.

Consultants are advised to contact BMA Pensions if they have any queries about whether such payments should be pensionable.

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**Information**

- TCS, paragraph 4.2.6

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**Part-time contracts**

Employers can offer part-time consultant contracts of between one and nine PAs per week. They are also able to offer annualised contracts where consultants wish to vary the number of PAs worked each week so that they can fit in other commitments e.g. childcare, research, etc.

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**Information**

- TCS, paragraphs 4.1.5 and 14.3.5

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**Locum appointments**

Locum consultants are employed to cover annual, study or sick leave of consultants in substantive posts, and also to provide cover for temporary vacancies. The length of appointments can vary from a few weeks when covering leave to several months. The guidance on locum appointments states that they should be short term only, although it may not be possible to determine the duration of the appointment at the outset. Where a locum appointment extends beyond three months, the situation should be reviewed, and again at three-monthly intervals thereafter, and this requirement should be included in any appointment letter. The guidance is that locum consultant appointments should be limited to a maximum period of one year.

Locums have no automatic entitlement to be appointed to the substantive post when it is filled, because all consultant appointments are subject to the statutory consultant appointment procedures. Except for the differences detailed below, all sections of the TCS apply to locum appointments.

**Basic salary**

Locums who have never held a substantive NHS consultant post are paid at the first pay point of the salary scale, unless they have gained consultant level experience outside the NHS, in which case this should be taken into account when agreeing starting salary.
Locums who hold a substantive consultant post (either with the employer or with another NHS employer) and will continue to do so once the locum post comes to an end are paid at their existing pay point.

Locums who do not currently hold a substantive consultant post but who have held one in the past (e.g. retired consultants) are paid the equivalent of their most recent pay point (excluding distinction awards, discretionary points and clinical excellence awards) or, if they have not previously been employed under the 2004 contract, the rate of pay consistent with their calculated seniority.

The provisions of paragraph 5.1.7 now apply when determining the starting salary for those taking up locum consultant appointments: “Where the salary of the previous regular appointment, including staff grade optional and associate specialist discretionary points, exceeds the minimum of the consultant salary scale, the consultant will be appointed to a point on the scale next above the pay rate of their previous regular appointment.” (PCS/DD/2013/3)

Pay progression
When 12 months' locum service has been completed (continuous or cumulative), the employer should assess whether the criteria for pay progression have been met. If part of the previous 12 months' service has been for one or more other NHS employers, the current employer should seek assurance from previous employers as to whether the criteria have been fulfilled.

Job planning
A locum consultant is appointed on the basis of agreeing to fulfil the existing job plan for the post. This job plan is open to review in line with the provisions for substantive consultant posts. Objectives should be agreed as part of the job planning process and locums should have the same access to resources e.g. for administrative support and continuing professional development, as other consultants.

Information
TCS, section 11
• Code of practice in the appointment and employment of locum doctors

Mediation and appeals processes
If there is a dispute over a job plan or a decision relating to pay progression, there is a process of mediation and appeal that can be followed.

Mediation
There is a two-stage mediation process. In the first stage, the consultant or the clinical manager should refer the dispute to the divisional medical director (or another designated person if the medical director is one of the parties to the initial decision) in writing within two weeks of the disagreement arising, setting out the nature of the dispute. The other party should then set out their position on the matter. There will then be a meeting, normally set up within three weeks of the referral, involving the clinical manager, the consultant and the divisional medical director. If
agreement is not reached, the consultant can refer the point of disagreement to the divisional chief executive, in writing, within two weeks of the decision. This is stage 2. Where the dispute is over pay progression, the consultant is entitled to invoke the stage 2 process straight away. If the consultant is not satisfied with the outcome, a formal appeal can be lodged.

**Appeal**
The consultant must lodge the appeal in writing to the chief executive within four weeks and the chief executive will then convene an appeal panel, which should normally meet within six weeks of the request. The membership of the panel is a chair nominated by the employer, a member nominated by the consultant and a third member from a list agreed between the NHS board and the LNC. The consultant can object on one occasion to the third member where there is a recognised incompatibility, who would then be replaced with an alternative.

The parties to the dispute submit written statements of case to the appeal panel five working days before the hearing. The consultant can either present their own case at the hearing or they can be assisted by a representative, who may be a member of BMA staff, but may not be someone acting in a professional legal capacity. The panel then makes a decision known to both parties, in writing, no later than 10 working days following the appeal. The decision of the appeal panel is final (on a majority basis) and is binding on both parties: no further right of appeal exists.

### Transferring to the 2004 contract from the old contract
Consultants in post prior to 1 April 2004 who are still on the pre-2004 contract have the option to transfer to the 2004 contract or retain their existing terms.

Where consultants transferring to the 2004 contract find that the combined total of their new basic pay and on-call availability supplement will be less than the combined total of their existing basic pay and intensity supplement, pay protection will apply. Basic pay for these purposes does not include extra PAs, so any extra PAs paid under the 2004 contract should be paid on top of the protected old salary. Pay protection is on a mark-time basis (i.e. until the new salary exceeds the salary at the point of transfer).
Job planning

A job plan is a detailed description of the duties and responsibilities of a consultant and of the supporting resources available to carry them out. Job planning has been a responsibility for all consultants in the NHS since 1991, but the 2004 consultant contract placed a renewed emphasis on ensuring that job plans are accurate and up to date. The planning system is based on a partnership approach between consultant and clinical manager.

The purpose of job planning

The job planning process is a prospective process that needs to be based on a partnership approach to enable consultants and employers to:
- effectively prioritise work and avoid excessive consultant workload
- agree how a consultant or consultant team can most effectively support the wider objectives of the service and meet the needs of patients
- agree how the NHS employer can best support a consultant in delivering these responsibilities
- provide the consultant with evidence for appraisal
- comply with the Working Time Regulations
- agree activity above the standard commitment via prospectively agreed extra programmed activities (EPAs).

Job planning can therefore be of great benefit and all consultants should adequately prepare for, and participate actively in, job planning on an annual basis, especially as participation in the process will be a factor in informing pay progression.

The process of job planning

The TCS are clear that the job plan is agreed between the consultant and the employer. This is the medical director/director of public health, the clinical director, or other lead clinician nominated by the medical director/DPH. A non-medical manager can only be present at a job planning meeting with the agreement of the consultant.

The consultant should be the key player in drawing up the job plan. In advance of any job planning meeting, the consultant should consider the following points:
- what is currently in the job plan
- what work is actually undertaken currently (this may well be different from the existing job plan)
- how the work that is currently undertaken fits into the contract’s definitions (e.g. what is direct clinical care, what is supporting professional activity)
- what the consultant would like to see changed in the job in the future.
The consultant and the medical manager should then discuss all elements of the consultant’s current and future responsibilities and agree the job plan document. Where agreement cannot be reached, the mediation and appeals processes can be invoked.

**Format of job plans**

**National model**

There is an agreed national model of a job plan contained in appendix 4 of the TCS.

**Job plan content**

The job plan will detail the consultant’s commitment to the NHS. It will set out:

- a timetable of activities such as out-patient clinics, ward rounds and operating sessions, which have a specific location and time
- activities which are not undertaken at specific locations or times
- activities during premium rate hours of work
- a summary of the total number of hours of each type of activity in the timetable
- the availability supplement category
- any arrangements for extra PAs, to be covered by a separate contract and schedule
- a list of agreed objectives, with resources required (see below)
- the consultant’s accountability arrangements.

Some of these issues have been covered in detail in the previous section. Where this is not the case, further information is outlined below.

**Objectives**

Objectives are a contractual expectation for consultants. Objectives could relate to activity and efficiency, clinical outcomes, clinical standards, local service objectives or management of resources. They may flow from discussions and agreement at the annual appraisal. Consultants will need to make every reasonable effort to meet these objectives to achieve pay progression and so they must be appropriate, identified and, most importantly, agreed between the consultant and employer. It is not reasonable to set objectives where there are significant influencing factors outside the consultant’s control e.g. waiting time targets. Consultants have no obligation to sign up to objectives that are unreasonable.

Where objectives are set well, they provide focus for a consultant’s personal development and also for the service provision and development necessary to maintain a high quality standard of patient care.

**Information**

- TCS, section 3, paragraphs 3.2.16-3.2.21

**Fee-paying work**

The TCS operate on the general principle that consultants are entitled to receive fees for work done in their own time, but should not receive extra fees for work done during NHS PAs i.e. not be paid twice for the same work. However, there is scope for consultants to retain fees for work
done in their PAs where there is ‘minimal disruption to NHS work’. Alternatively, consultants can agree to ensure that their NHS work is made up at another time – effectively time shifting their work. Another option is to negotiate that the work is part of the working week, and through the job planning process, negotiate an allocation in terms of PAs.

It is open to LNCs to reach agreements with employers on how this work will be treated.

All family planning work by consultants on the 2004 contract is undertaken as part of their agreed PAs and there is no fee-paying option. Individuals who hold religious or moral objections to carrying out family planning work may declare such objections on appointment, or at any point at which they may be asked to commence such work, in which case they will be excused from undertaking such duties.

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| • TCS, section 9, paragraph 9.4.1  
• PCS (DD) 2005/13 |

**Private practice**
The job plan should include details of any private work undertaken by the consultant. This is a contractual requirement under the 2004 contract. Consultants should identify any regular private commitments and provide information on the planned location, timing and the broad type of work that is being undertaken. The employer has no right to ask for financial details relating to private practice for consultants on the 2004 contract. Details are covered in the code of conduct for private practice, contained in appendix 8 of the TCS.

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**Supporting resources**
The job plan should identify and agree the resources that the consultant needs to do the job properly. This gives the opportunity to make sure that the employer is formally aware of the supporting resources required, for example secretarial support, medical staff support, office space, equipment and information technology. A lack of appropriate supporting resources could have an impact upon consultants meeting their objectives. It is therefore essential that the required resources are identified when job plans are agreed. Pay progression cannot be withheld if consultants have not met objectives for reasons beyond their control.

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Job plan review

Annual review
It is a contractual obligation for all consultants to have an annual job plan review. Information arising from annual appraisal could inform this process, and so consultants and employers may want to link the timing of the job plan review to some time after the appraisal. The review should consider progress against objectives and factors affecting the achievement of objectives; adequacy of resources; potential changes to duties or responsibilities; ways to improve workload management and planning of careers.

Following the review, the medical manager will complete documentation to confirm progression through the seniority points.

Interim review
The consultant or employer is entitled to request an interim review if changes to staffing resources, or working practices or the consultant's circumstances, requires it. The contract also provides for an interim job plan review to be carried out where a consultant believes that the average workload exceeds the amount of work for which the consultant has contracted as PAs agreed in the job plan.

SSASC and SCC have agreed the following joint statement with MSG regarding SPA time for appraisers: “BMA Scotland and MSG recognise that career grade doctors working for NHSScotland are required to have an annual appraisal. Therefore, it is important that consultants and SAS doctors who have undergone appraiser training have sufficient time in their job plans to fulfil their appraiser role effectively. When a consultant or an SAS doctor becomes a trained appraiser, a job plan review will normally be appropriate, to ensure that the role is planned into their agreed work schedule.”

If there is a disagreement/dispute about the job plan, the mediation and appeals processes should be used.

Information
• TCS, section 3.3 and 4.6
• CEL (2007)2 Recommended documentation for seniority progression within the consultant contract

Specialty specific job plan guidance
Specific guidance on job plans for the following specialties is available on the BMA website: Anaesthesia and pain management, Chemical pathology, Community paediatrics, Diagnostic radiology, Emergency medicine, Genito-Urinary medicine, Histopathology, Medical specialties, Microbiology, Obstetrics and gynaecology, Oral and maxillo facial surgery, Orthodontics, Paediatric dentistry, Pain management, and Restorative dentistry. This guidance has been produced for England only, and the contractual arrangements are different in some respects in Scotland. However, the guidance does provide useful information.

Information
• TCS, section 3
Other terms and conditions of service (TCS) issues

Pay
The Doctors and Dentists Review Body (DDRB) reports each year to the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Government (and to the relevant ministers in England, Northern Ireland and Wales), usually in January or February. The report is made public several weeks later, for implementation on 1 April of the same year. The DDRB’s remit is strictly ‘to advise the Prime Minister’ but its independence has been held as important by the BMA. Each year the health departments, employers’ organisations and the BMA present written evidence to the DDRB in September, stating their case on appropriate remuneration for the forthcoming year, and this is supplemented by oral evidence in November.

The DDRB recommends salary increases for consultants and other doctors and recommends the value and number of distinction awards and the value of discretionary points. The government will then make a decision on the DDRB recommendations; when the increases are implemented they are issued in the form of a circular from the SGHSCD and incorporated into the national Terms and Conditions of Service for the Consultant Grade (Scotland).

Information
- Current pay scales
- BMA Guidance Note: Doctors’ pay
  https://bma.org.uk/practical-support-at-work/pay-fees-allowances/how-is-doctors-pay-decided

References are made throughout this section to paragraphs in the General Whitley Council (GWC) handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the GWC has been replaced by an NHS Staff Council. Some sections of the GWC handbook have been replaced by updated terms and conditions but not all. For the time being, parts of the GWC handbook continue to apply to consultants. Appendix 10 of the TCS lists the relevant sections.

Expenses and allowances
Travel expenses
Consultants required to travel on NHS business are entitled to claim reimbursement of travelling expenses. This will be either the cost of public transport or a mileage allowance. It should be noted that part of the mileage allowance is taxable. Possession and use of a motor car is rarely a contractual requirement even for community-based staff. Consultants may be offered a crown or lease car.

Lease or crown cars
The crown car scheme for hospital doctors was introduced in 1990. In the 2004 contract, reference is made to lease cars as opposed to crown cars. A lease or crown car is a vehicle which is
owned or contract-hired by an employer. Consultants are not automatically entitled to a crown car, but are offered one if the employer considers it economic or in the interests of the service to do so.

Lease car schemes operate locally and can vary quite considerably. Employers may also have their own schemes. Consultants should contact their employer’s human resources department or LNC representative for further information.

Consultants interested in crown cars should be aware that the scheme will be economically advantageous only to some individuals, depending on variables such as annual private and business mileage, size of car and the tax position. They are therefore advised to proceed with caution and should seek advice from the BMA and/or their accountant.

**Mileage allowances for consultants not offered lease cars**

Consultants not offered lease cars who are required to use their own car on NHS business, are entitled to allowances at the standard rate unless they are classified as regular users. Standard and regular user mileage rates vary according to engine capacity.

The unions representing Agenda for Change staff agreed at UK level to new mileage rates as part of a package of changes to the arrangements for reimbursement of NHS employee business travel costs. These new arrangements include the introduction of a single rate per mile, regardless of vehicle engine size, with one rate for annual mileage up to 3,500 miles a year and a lower rate for mileage beyond that. There is also provision for regular uprating of the allowances, using independent figures produced by the AA on motoring costs. For more details see [http://www.sehd.scot.nhs.uk/pcs/PCS2013(AFC)03.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2013(AFC)03.pdf)

The mileage rate paid to regular users is lower than the standard rate, but regular users are also paid a lump sum in equal monthly instalments regardless of the mileage covered.

Consultants who fulfil any of the following criteria are paid at regular user rates:

- travel an average of more than 3,500 miles a year on official business; or
- travel on average at least 1,250 miles a year on official business; and
  - necessarily use their cars an average of three days a week; or
  - spend an average of at least 50 per cent of their time in travelling in the course of NHS business (this time to include the duties performed during the visits)

- are classified as ‘essential users’ because they fulfil the following criteria:
  - travel on average at least 1,250 miles (other than normal travel between home or private practice premises and principal hospital) each year; and
  - have ultimate clinical responsibility, or on-call responsibility normally controlled by a rota system, for the diagnosis and treatment of patients in hospital with emergency conditions which require them to be immediately available for recall; and
  - are expected to be recalled to hospital in an emergency at an average rate of twice or more during a working week, the rate of emergency call out being averaged over the year but excluding periods of leave.

Classification as an essential user only results in access to the regular user category and has no other effect.
Mileage allowances for consultants who refuse a lease or crown car
Special provisions apply to those who refuse a lease or crown car.

Public transport rate
The public transport rate is payable when consultants use their private cars when travel by public transport would be more appropriate.

Official journeys
The journeys listed below are classified as official business and mileage allowance may be claimed:
• Principal hospital (i.e. the hospital where the consultant's principal duties lie) and return to any destination, and travel between destinations, on official business.
• Home to any destination other than the principal hospital and return, on official business, subject to a maximum of the distance from the principal hospital to the place visited plus 10 miles in each direction or the actual mileage, whichever is the less.
• Home to principal hospital and return, when the consultant is called out in an emergency.
• Home to principal hospital and return, subject to a maximum of 10 miles in each direction, when consultants use their cars for subsequent official journeys, or where there is an acknowledged extensive liability to make emergency domiciliary visits.

Information
• TCS, section 8
• https://bma.org.uk/practical-support-at-work/pay-fees-allowances

Removal expenses
The provisions of the GWC Conditions of Service apply to consultants’ removal expenses. There is an entitlement to receive reimbursement in certain circumstances, for example, if a consultant is required to move by the employer, but significant discretion is left to employers. Employers determine the scope and level of financial assistance to be offered to the prospective employee prior to the post being accepted.

Consultants need to be aware that expenses offered may vary, although the GWC scheme does indicate that expenses should be based on costs actually incurred.

The LNC for the NHS board should be involved in agreeing the removal expenses package and consultants should ensure that they are aware of the level of assistance which will be provided, the
aspects of removal costs which will be reimbursed, and the upper limit of payment in normal circumstances before accepting a post. Advice should be sought on what is actually covered by the local scheme and not just the amounts reimbursed. In particular, consultants should note that employers may require that removal expenses are repaid in full or in part if they move to another employer within a certain period of time. The extent to which the expenses must be repaid under these circumstances is at the employer’s discretion, and may be dependent on the length of employment. Additionally, removal expenses in excess of a certain amount are taxable, and many employers set upper limits on the expenses payable in line with the tax threshold. A copy of the employer’s removal expenses policy should be available from the employer.

Before accepting an appointment, consultants who have to move to take up that appointment should contact the new employer as early as possible to ascertain whether or not they are eligible for removal expenses. It is important that any negotiation of removal expenses takes place before the post is accepted. Confirmation of any agreement with an employer should be obtained in writing.

### Information
- TCS, paragraph 8.6.1
- GWC Conditions of Service, section 26
- BMA Guidance: Removal and associated expenses for NHS medical staff

### Telephones

#### Provision of telephones

It is normally a contractual requirement for consultants to be contactable by telephone. Employers should pay for the cost of installation and rental of telephones where it is essential for the efficiency of the service that the consultant should be on call outside normal working hours and the telephone is the only practicable method of communication with the consultant. In most cases the payment by employers of installation and rental costs is taxable.

#### Official business calls

Consultants may claim the cost of outgoing calls made on official business from the employer.

#### Mobile phones

Consultants should be able to negotiate with the employer the provision of a mobile phone or pager and/or subsequent outgoing NHS business calls where this is needed for work purposes. Where there is no clear employer agreement on mobile phones, the issue should be raised with the LNC to produce clear guidance for consultants.

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### Information
- NHS Circular 1979 (PCS) 32 Provision of Telephones for Medical and Dental Staff
Subsistence allowances

When consultants are required to be away from their main or regular place of work on employer’s business, they may claim subsistence allowances in accordance with the GWC Conditions of Service. Subsistence allowances, which are payable in addition to travelling expenses, can be claimed for approved overnight stays, daytime meals and late night duties expenses. Situations where subsistence allowances may be payable include during periods of approved study leave and, at the discretion of the prospective employer, during a search for suitable permanent accommodation in a new area as part of removal expenses. Reimbursement should be claimed only for the expenses which consultants have actually incurred, up to a maximum of the appropriate allowance. Vouchers or receipts are required. Where the subsistence allowances have been exceeded, reimbursement of the excess costs is discretionary. Consultants are normally required to submit claims at intervals of not more than one month and as soon as convenient after the end or the period to which the claim relates. Consultants are advised to check whether GWC arrangements apply locally since some employers may have introduced their own schemes. In any event, consultants are advised to check their entitlement before incurring expenditure.

Annual leave

Consultants are entitled to six weeks’ annual leave per year. The leave year runs from the date of taking up appointment as a consultant. It should be noted that this entitlement is not affected by the provisions of the European Working Time Directive (EWTD), which refers to a minimum statutory entitlement of four weeks per year.

The contract defines the number of days to which ‘six weeks’ equates, where leave is taken in periods of less than one week. This is assessed for both full and part-time consultants by calculating the average number of days per week when the consultant is on duty as agreed in the job plan, including on-call availability, and multiplying it by six.

This means, since consultants can be available on call at weekends, that such availability should be factored into the calculation of leave entitlement in terms of days where less than complete weeks are taken. A full-time consultant available on a one in four rota, for example, is on duty or available for an average of 5.5 days per week. This is calculated as five days Monday to Friday, and two days at weekends every four weeks (0.5 days per week), totalling 5.5 days. Multiplying this average number of 5.5 days on duty or available each week by the entitlement of six weeks permits a total of 33 days’ leave. The following table, applicable to full-time consultants, might be helpful.
Consultants with substantive contracts may transfer up to five days of leave not taken in a leave year into the next leave year, subject to the needs of the service. Consultants must notify their employers when they wish to take annual leave and the granting of such leave is subject to approved arrangements having been made for the consultant’s work to be done in their absence. It may be helpful to administer annual leave arrangements within clinical directorates.

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<td>1 in 2</td>
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<td>1 in 5 to 1 in 8</td>
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<td>1 in 9 to 1 in 24</td>
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<td>1 in 25 or less frequent</td>
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Public holidays
Consultants are entitled to 10 paid public holidays each year. Consultants who are required to be on call on a public holiday will receive a day off in lieu. Consultants who are required to be present in the hospital/other place of work, or undertake complex telephone consultations, between the hours of and on a public holiday will receive a day off in lieu.

Some LNCs have negotiated local arrangements which have converted 2 of the public holidays into annual leave – consultants should therefore check the position in their board.

Study and professional leave
Consultants’ study leave is mainly used to enable them to participate in continuing professional development (CPD). It therefore plays an important role in ensuring the highest standard of patient care, and consultants should be encouraged to take such leave. It is recommended in the TCS that consultants should receive study leave with pay and expenses, within a maximum of 30 days in a period of three years. Employers may, at their discretion, grant study leave above the periods recommended with or without pay and expenses.
The day-to-day administration of study leave rests with the employer, and there are considerable variations between employers in the way that study leave applications are dealt with. In practice, most seem to allocate a fixed amount of money for each consultant to use either per year or over a three-year period. Some employers have unrealistically low study leave budgets.

Every consultant is required by their royal college to attend CPD courses which help to maintain an acceptable standard of clinical skill. Under the GMC’s ‘Duties of a Doctor’, consultants have a clear responsibility to keep up to date with current best practice. The royal colleges have highly developed programmes on CPD and colleges can provide details of the current CPD requirements in individual specialties.

There are a number of factors to be taken into account when considering study leave applications:
- once a study leave application within the is accepted, full reimbursement of associated expenses will be made
- where leave is taken elsewhere within the European Union, it will be granted with reimbursement of associated expenses at a level agreed between the consultant and the employer, which will normally be comparable with the level of expenses available for study leave within the UK
- the right of a consultant to take study leave should not depend on the employer’s financial position
- employers should not turn down study leave applications on non-educational, including financial, grounds
- study leave should not be used for inappropriate purposes, for example attending consultant appointment committees.

Where study leave claims are turned down or expenses not paid, consultants have a number of options open to them, including pursuing the issue of non-payment of expenses through the courts as a civil claim. Additionally, cases may be pursued as a formal grievance in accordance with the local grievance procedure. In any event, consultants are advised to contact the BMA for advice and appropriate support.

Information
- TCS, section 7.3
- SHM 29/1967; 41/1968; DS (MD) 7/1973; DS (78) 50; SOHHD/DGM (1991) 64 – all SGHSCD circulars concerning study leave
Sick leave
The following information is based on the provisions of the TCS and GWC conditions.

Procedure to be followed
Consultants should inform their employer immediately according to local arrangements if they are unable to work because of illness. If the illness lasts longer than three calendar days, a self-certificate must be submitted within the first seven days of absence. Further statements in the form of a medical certificate provided by another doctor must be submitted for any absence extending beyond the first seven days. These further statements will not normally be submitted more frequently than once every seven days, although the employer is entitled to ask for more frequent statements. The employer may also insist that the consultant undergoes a medical examination conducted by its nominated doctor.

Hospital admission
Consultants admitted to hospital must submit a doctor's statement on admission and discharge, or a self-certificate if absent for seven days or less.

Allowances
An allowance is paid during sick leave on a sliding scale according to length of service, with a minimum of one month's full pay and a maximum of six months' full pay and six months' half pay, although the employer has discretion to extend the application of the scale in exceptional cases. Most consultants are entitled by their previous service to the maximum allowance. The calculation takes account of any sick leave already taken in the 12 months immediately prior to the first day of absence.

Exclusions
An allowance is not normally paid in the following cases:
- accident due to active participation in sport as a professional
- contributory negligence
- once employment is terminated, for example because of permanent ill health, resignation, or any other reason
- failure to observe the conditions of the scheme
- conduct prejudicial to recovery.

Information
- TCS, section 7.5
- GWC Conditions of Service, sections 1, 57 and 61
- NHS Circular 1983 (11), Introduction of Statutory Sick Pay
- CEL 17 (2009), Carry Over of Holiday Entitlement during Long Term Sick Leave
Income during sick leave
The allowance paid by the employer during absence on sick leave must not result in consultants receiving more than their normal salary for the period. In practice, many employers pay the consultant as normal and make separate arrangements to claim back the statutory sick pay from HM Revenue and Customs (HMRC), stating this element on the pay slip. Special arrangements for pay and sick leave entitlement exist in the case of a consultant receiving damages from a third party after an accident. Further advice is available from the BMA. Disputes are dealt with by HMRC offices.

Private practice during sick leave
Consultants should be extremely cautious during sick leave with regard to the other activities they normally carry out. Some employers may regard the undertaking of private practice as a serious disciplinary offence. In certain circumstances, however, employers might allow a consultant to undertake private work, for example to facilitate a gradual return to work; consultants should always check with their employer before undertaking work while on sick leave and should seek advice from the BMA.

Illness during annual leave
Consultants who fall ill during annual leave and produce a statement to that effect are regarded as being on sick leave from the date of the statement and paid accordingly. The annual leave may then be taken at a later date. This does not apply if the consultant falls ill on a public holiday.

Help and advice for sick doctors
Details of services offering help and advice to sick doctors can be found in the section on health issues.

Special leave
Special leave for consultants with or without pay may be granted at the discretion of the employer with the following qualifications:
• jury service: normally consultants are entitled to be excused jury service
• contact with notifiable diseases: in general, the situation will not arise in the case of consultants who come into contact with notifiable diseases because of their professional position.

Leave for attendance as an expert witness
Leave for consultants attending court as expert witnesses is a contentious area, with some employers taking the view that this should be categorised as fee paying work, and consequently special leave with pay may be refused. However, it is arguable that it would be unreasonable for employers to object to consultants carrying out this work since it is part of the judicial process of the state. Consultants are entitled to time off with pay to attend court as professional witnesses, in connection with their own patients.

Leave for trade union duties and activities
The Trade Union and Labour Relations (Consolidation) Act 1992 places an obligation on employers to allow officials of recognised trade unions, which would include BMA local and national representatives and members of BMA accredited LNCs, to take reasonable time off with pay to undertake trade union duties during working hours. Under the Act, ‘duties would be taken to refer
to circumstances where an individual would be acting as a representative of the profession, either locally or nationally’.

The Act also requires an employer to allow members of recognised trade unions to take reasonable time off, not necessarily with pay, for the purpose of taking part in trade union activity, such as BMA meetings.

The way in which these matters should work in practice locally will be defined in local facilities agreements agreed by Health Boards with Trades Unions and Professional Associations, including the BMA.

### Information
- TCS, section 7.6
- GWC Conditions of Service, sections 12 and 38
- Trade Union and Labour Relations (Consolidation) Act 1992, sections 168-73

### Sabbatical leave
Under the contract, consultants are eligible, after seven years’ service as a consultant, to apply for one period of sabbatical leave of up to six weeks or, after 10 years’ service, for up to three months’ sabbatical leave. If either of these options is granted with pay, then no further period of paid sabbatical leave will be granted until retirement. The following provisions also apply:

- approved arrangements must be made to cover the absence on sabbatical
- the consultant must make a stated case explaining how the leave will be used and will benefit the NHS, which must have the written support of the clinical director/manager
- the employer has discretion as to whether to meet any travel and accommodation expenses in part or in full
- if sabbatical leave has been granted without pay, the employer has discretion to grant additional leave at intervals of no less than seven years after the first period.

### Information
- TCS, section 7.4
Employment Break Scheme

NHS employers should provide all staff with access to an employment break scheme. The scheme should be agreed between employers and local staff representatives. The scheme should be viewed with others, particularly those relating to flexible working, balancing work and personal life, and provisions for carers, as part of the commitment to arrangements which enable employees to balance paid work with their other commitments and responsibilities.

Information

- TCS, Appendix 12

Maternity, paternity, parental and adoptive leave and surrogacy

Consultants, like other employees, have certain minimum statutory rights to maternity and parental (including paternity) leave and pay. In addition, under the NHS Staff conditions of service, which have been incorporated into the TCS for consultants, consultants can take advantage of more beneficial occupational arrangements for maternity leave and pay.

Entitlements under both the statutory and NHS Staff schemes depend on certain qualifying conditions, and the application of, and interrelationship between, the schemes, is a complicated area and the BMA Guidance provides more detail.

Under the current NHS Staff maternity leave scheme, consultants must have normally had 12 months’ service with one or more NHS employers, with no break in service of more than three calendar months, at the beginning of the 11th week before the expected week of childbirth to qualify for maternity leave and pay. Notice of intention to return to work must be given in writing before the end of the 15th week before the expected date of childbirth, and failure to return to work for the same or another NHS employer for a minimum period of three months may result in liability to repay some or all of the maternity pay.

Maternity leave with pay consists of 26 weeks pay made up of eight weeks at full pay (less any statutory maternity pay or maternity allowance, including any dependents’ allowances receivable) and 18 weeks at half of full pay (plus any SMP or MA, including any dependents’ allowances receivable), providing the total does not exceed full pay. By prior agreement with the employer, occupational maternity pay may be paid in a different way, for example, a combination of full pay and half pay or a fixed amount spread equally over the maternity leave period. The maximum entitlement to leave is 52 weeks (including paid and unpaid). All employees are entitled to 26 weeks’ unpaid leave. The scheme also covers areas including health and safety of employees pre and post birth, return to flexible working arrangements and contractual entitlements during maternity leave.

Paternity leave and pay is available to employees following the birth of a child or placement of a child for adoption. Following the birth of a child, the new rights to paternity leave and pay give eligible employees the right to take paid leave to care for the child or support the mother. There is a NHS scheme and a statutory scheme.
Injury allowance

Changes have been made to the NHS Injury Benefit Scheme. Historically this scheme provided for the payment of either a Temporary Injury Allowance (TIA) or a Permanent Injury Benefit (PIB) where injury or illness occurred as a result of NHS employment.

NHS staff who were covered by the Injury Benefit scheme will still be able to claim either TIA or PIB in respect of an injury or illness which is wholly or mainly attributable to NHS employment and that occurred on or before 30 March 2013. The Injury Benefit Regulations have been amended to prevent future claims in respect of injury or illness which occurred on or after 31 March 2013.

The NHS Staff Council has approved a new section in the NHS Terms and Conditions of Service Handbook (Section 22) which introduces a contractual right to injury allowance which replaces the statutory Injury Benefit provisions. The new contractual injury allowance arrangements apply to all doctors and dentists employed by NHS Boards, Special Health Boards and NHS National Services Scotland.

Medical indemnity

The NHS provides medical indemnity for its staff via the NHS indemnity scheme. The scheme ensures that employers bear the financial costs arising from claims for negligence against staff carrying out work which falls under their contract. Along with other NHS employed doctors, consultants are covered by NHS indemnity for the work they undertake under their NHS contracts. If a consultant is treating NHS patients under a contract with their employer (whether that is the main contract of employment or a separate contract issued specifically for dealing with waiting list patients), the consultant is covered by NHS indemnity.

The NHS indemnity scheme covers:
- work under NHS contracts including in non-NHS locations
- hospital doctor locum work, whether through a locum agency or directly with the employer
- domiciliary visits.
The NHS indemnity scheme does not necessarily cover:

- private practice work
- fee-paying work i.e. reports for a third party where a fee may be charged
- ‘good Samaritan’ work, such as assisting at a traffic accident
- costs in GMC proceedings
- inter-hospital transfer.

Consultants should ensure in each case that the work is covered either by NHS indemnity or by another employer or by their defence body, taking out additional cover if necessary.

Under the NHS indemnity scheme, employers, being financially liable for the medical negligence of their staff, have the ultimate right to decide how the defence of any case is handled. Subject to this, doctors may be represented separately at their own cost in any case of alleged negligence. However, they are then liable for any additional expenses of an employer if they elect to be separately defended. If doctors unreasonably fail to cooperate fully in the defence of the claim or action against the employer, the employer may, at its discretion, seek to recover part or all of any liability which it may incur.

The Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) is a risk transfer and financing scheme for NHSScotland, which has been developed by the SGHSCD in partnership with Willis Ltd, the appointed scheme manager. Its primary objective is to provide cost-effective risk pooling and claims management arrangements for ‘s NHS boards and special health boards.

The BMA advises that it is essential that all consultants retain some form of personal indemnity insurance to cover any non-NHS work, as well as NHS indemnity cover. Consultants should consult the defence bodies to determine the degree of cover required and the schemes available.

**Information**

- MEL (2000) 18 Clinical Negligence and Other Risks Indemnity Scheme
- HDL (2005) 12, paragraph 11 regarding WLI work at the Golden Jubilee National Hospital
- BMA Members Guidance: NHS indemnity

**Grievance procedures**

Employers should have drawn up, in consultation with local staff representatives, procedures to enable employees to challenge an employer’s decision which may adversely affect their TCS. The procedure does not apply to settling differences relating to dismissal or any disciplinary matters; organisational change; or issues covered by the disputes procedure. The grievance procedure should be designed to provide a speedy resolution of the grievance as close as possible to the source and regard should be given to good industrial relations practice as set out in the ACAS Code of Practice. The procedures should provide for the reference of grievances to a person or body other than the employer, when both parties agree that this is appropriate.
Disputes procedures
The procedures for handling and resolving disputes that do not affect the TCS are determined locally. These procedures should be drawn up following consultation with local staff representatives and be based upon the principles set out by the GWC:
• disputes should be resolved at the lowest possible level of management and as close as possible to the source of the dispute
• as far as possible, disputes should be settled locally without formal reference to a person or body outside the employing authority
• disputes should be settled as speedily as possible.

The GWC further suggests that an employee should have the right to be represented.

Notice of termination of employment
If the employer terminates the contract, three months’ notice in writing must be given to the consultant. Likewise, consultants wishing to terminate their employment must also give the employer three months’ notice. A notice period of less than three months may only be given with the express agreement of the other party save in circumstances of dismissal on grounds of gross misconduct or resignation on grounds of constructive dismissal.

Local contractual variations
NHS Boards must comply with the statutory position in relation to their powers to employ staff. This means that, where pay and conditions of service for a class of NHS staff have been agreed in negotiations and approved or authorised by Scottish ministers, boards must employ such staff on those terms and conditions.
Where boards want to employ staff on non-approved terms and conditions, for example, for recruitment and retention purposes, then they can apply to Scottish ministers for an order allowing a variation. Subject to any variation which might be granted by ministers, all staff must be employed on nationally approved terms, pay and conditions.

**Revalidation**

Revalidation is the process for doctors to positively affirm to the General Medical Council (GMC) that they are up to date and fit to practise. It applies to all licensed doctors in the UK working in the NHS and the private sector and all branches of practice. Doctors will need to meet the standards set by the GMC, taking into account guidance for their specialty, to maintain their license to practice (since 2009 all doctors on the medical register who wish to practise medicine have been required to have a Licence to Practise).

It represents a way of regulating the medical profession that will provide a focus for doctors’ efforts to maintain and improve their practice; facilitate the organisations in which doctors’ work to support them in keeping their practice up to date; and encourage patients and the public to provide feedback about the medical care they receive from doctors.

Revalidation is based on a local evaluation of doctors’ performance through appraisal. Doctors are expected to participate in annual appraisal in the workplace and must maintain a folder or portfolio of supporting information to bring to their appraisals as a basis for discussion. There will be some types of supporting information that all doctors will be expected to provide at appraisal over a revalidation cycle. However, doctors can take any other additional information to demonstrate their practice at appraisal.

Information from the appraisal is provided to a Responsible Officer who will make a recommendation to the GMC, every five years, on whether to revalidate a doctor. In order to revalidate a doctor, the GMC will require assurance that a doctor is fit to practise. This will be predominantly based upon the satisfactory completion of 5 annual appraisals. Multisource feedback from both patients (for those doctors who see patients as part of their medical practice) and colleagues will be required at least once during the five year cycle. For the majority of consultants who work in NHS Scotland the RO will be the Medical Director of the Health Board where they work. Generally, doctors will relate to the RO where they undertake the majority of their work.

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Appraisal

Introduction
This section summarises and supplements the guidance on the appraisal scheme for consultants in the NHS. Appraisal is a contractual requirement for all consultants and must be carried out annually. Failure to participate satisfactorily in annual appraisal can result in a decision to withhold pay progression in any year. In addition, employers are required to indicate in the distinction award review process whether a consultant has participated fully in appraisal within the last year.


Definition of appraisal
Appraisal should be a professional process of constructive dialogue, in which the consultant has a formal structured opportunity to reflect on their work and to consider how their effectiveness might be improved. This is mutually beneficial to the individual being appraised and the organisation in which they work.

Appraisal is a forward-looking process essential for the development and educational needs of an individual. It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance. However, it can help to recognise, at an early stage, developing poor performance or ill health, which may affect practice.

Although the appraisal may refer to the job plan, the two should be dealt with separately and the 2004 contract specifically states that these are separate processes. Time allocated for appraisal should not be spent on job plan work and vice versa. The outcome of the appraisal discussion should inform the job plan.

Appraisal process and content
Under the Medical Profession (Responsible Officers) Regulations 2010, the Responsible Officer is responsible for ensuring systems of appraisal are in place and for making recommendations on the fitness to practise of doctors within an NHS Board. The RO is thus responsible to both his/her NHS Board as Medical Director, and to the GMC in terms of the reserved functions covered by the RO Regulations. Medical Directors as the Responsible Officer are accountable to their board for the appraisal process and must ensure that appraisers are properly trained to carry out this role and are in a position to undertake appraisal of clinical performance, service delivery and management issues.

The GMC has produced a Framework for Appraisal and Revalidation based on the document, Good Medical Practice.7 which describes four domains and 12 attributes of good medical practice. This is the framework against which a doctor should demonstrate fitness to practise over the 5 year revalidation cycle. The Framework is available on the GMC’s website [www.gmc-uk.org]. The GMC’s core headings are: good clinical care; maintaining good medical practice; relationships with patients; working with colleagues; teaching and training; probity and health.
Who undertakes the appraisal
In secondary care, the AMD/ Clinical Director or the Appraisal Lead will select an appraiser for the doctor from the NHS Board’s approved list of trained appraisers. In normal circumstances he/she will be in current clinical practice and drawn from the same broad specialty as the appraisee (e.g. a surgeon by a surgeon, a laboratory doctor by a laboratory doctor); this may not be possible however for highly specialised doctors or very small specialties and is therefore NOT guaranteed.

The appraisee is entitled to request one alternate choice of appraiser. If the appraisee has legitimate reason not to accept the second appraiser then the Appraisal Lead/Advisor will appoint another trained appraiser, and that decision will be final. The guidance recognises that there are both advantages and disadvantages in having continuity of appraiser throughout the 5 year appraisal cycle, and suggests it may be desirable that an appraisee should have two different appraisers during each five year revalidation cycle.

In order that appraisal is delivered to a uniform high standard across the country, all appraisers must undertake the National Appraiser training scheme and any subsequent training. Full details are laid out in Medical Revalidation (Annual Appraisal Documentation): CEL 31 2012 http://www.sehd.scot.nhs.uk/mels/CEL2012_31.pdf

Preparation
The consultant being appraised should prepare for the appraisal by identifying those issues which they wish to raise with the appraiser and prepare an outline personal development plan. All appraisals should use the most up-to-date version of the nationally agreed appraisal documentation. The GMC has outlined the minimum supporting information that doctors will be required to bring to an appraisal. It is a requirement of appraisal for revalidation that feedback is obtained from workplace colleagues (MSF) at least once every 5 years using an MSF tool which complies with GMC guidance.

Appraisees should also submit any data that is considered relevant to the appraisal. This must include sufficient relevant data relating to other work carried out external to the employer (e.g. in private practice). The information provided should address the professional roles that the doctor performs at the time of appraisal, which may differ from his/her job title, or previous specialist registration.

The information and paperwork to be used in the appraisal meeting should be shared between the appraiser and the appraisee at least two weeks in advance to allow for adequate preparation for the meeting and validation of supporting information. Preparation time and time for carrying out appraisals are not additional to consultants’ other duties and responsibilities and therefore should be included in job plans.

Appraisal content
The GMC has produced a Framework for Appraisal and Revalidation based on the document Good Medical Practice. This describes four domains and 12 attributes of good medical practice. This is the framework against which a doctor should demonstrate fitness to practice over the 5 year revalidation cycle, and which should be covered in medical appraisal and on which recommendations to revalidate doctors will be based.
The framework consists of four domains which cover the spectrum of medical practice. They are:
1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust

Each domain is described by three attributes. The attributes define the scope and purpose of each domain. These attributes relate to practices or principles of the profession as a whole.

There are six types of supporting information that the GMC expects doctors to provide and discuss at appraisal at least once in each five year cycle. They are:
1. Continuing professional development
2. Quality improvement activity
3. Significant events
4. Feedback from colleagues
5. Feedback from patients
6. Review of complaints and compliments

Information
- GMC website
  http://www.gmc-uk.org/doctors/revalidation.asp

Consultants should ensure that all aspects outlined above have been covered, that an opportunity has been given to raise matters of concern, and that the appraisal has not strayed from its remit.

Feedback
The GMC’s requirements for patient and colleague feedback are an integral part of revalidation.

Colleague Feedback (Multi-Source Feedback MSF)
It is a requirement of appraisal for revalidation that feedback is obtained from work colleagues (MSF) at least once every five years using an MSF tool which complies with GMC guidance.

Information
- A Guide to Appraisal for Medical Revalidation (CEL 31 (2012))

Patient Feedback
It is a requirement of appraisal for revalidation that feedback is obtained (where doctors have direct patient contact) from patients at least once every five years. It is recognised that doctors work in different environments however than therefore there is not a single process for patient
feedback for all doctors in NHS Scotland, and patient feedback will be undertaken locally. However the use of the CARE questionnaire has been endorsed for both primary and secondary care.

Feedback from patients must be collected using questionnaires that comply with GMC guidance. Doctors should receive questionnaire feedback prior to the appraisal to give time for them to consider and reflect upon it. Questionnaires should be administered independently of the doctor and the appraiser. It is recommended that 25 completed patient questionnaires should be obtained in a twelve month period.

For ease of administration it is advised that patient and colleague feedback are not generally undertaken in the same year, but ideally both should be undertaken in the first three years of the revalidation cycle.

Information
- A Guide to Appraisal for Medical Revalidation (CEL 31 (2012))

Outcomes of appraisal
The maximum benefit from the appraisal process can only be realised where there is openness between the appraisee and appraiser. The appraisal should identify individual needs which will be addressed through the personal development plan. The plan will also provide the basis for a review with specialty teams of their working practices, resource needs and clinical governance issues. All records must be held on a secure basis and access/use must comply fully with the requirements of the Data Protection Act.

Appraisal meetings should be conducted in private and the completed documentation will be treated as confidential. If serious issues of clinical governance or probity become apparent then the appraiser is professionally obliged to break confidence and take appropriate action.

All appraisals should use the most up-to-date version of the nationally agreed appraisal documentation. The SOAR platform has been developed to accommodate the appraisal documentation. The appraiser and appraise have access to all the documentation associated with the appraisal, including previous appraisals. Once the form 4/GPScot 4/PDP has been agreed and signed off by both parties the appraiser will cease to have access to this information. Where there is disagreement which cannot be resolved at the meeting, this should be recorded and a meeting should take place in the presence of the medical director to discuss the specific points of disagreement.

The Form 4/GP Scot 4/PDP will be sent by the appraiser to the appraisee's medical director/clinical director (or equivalent medical line manager). The RO will have access to all Form 4s/Scot 4s/PDPs, and may require access to the full appraisal documentation in the event that a significant concern is raised about the doctor's performance. The Appraisal Lead/Advisor will have access to all Form 4s/Scot 4s/PDPs for the purposes of quality control of appraisal.
The Medical Director as Responsible Officer in Scotland is accountable for ensuring that all consultants undergo an annual appraisal and that there are appropriate, trained appraisers in all cases.

The chief executive should submit an annual report on the process and operation of the appraisal scheme to the board. This information will be shared and discussed with the medical staff committee or its equivalent and the LNC. The annual report must not refer, explicitly or implicitly, to any individuals who have been appraised. The report will highlight any employer-wide issues and action arising out of the appraisal process, e.g. educational developments, service needs.

**Serious concerns arising during the appraisal process**

If issues arise during the appraisal process which raises serious concerns about patient safety, a doctor’s practice or probity, the appraiser should stop the appraisal and take appropriate action. If after the appraisal interview the appraiser realises such issues have arisen, the appraiser is obliged to break confidence and take appropriate action. If this happens after the appraisal process has been completed (i.e. after the appraiser and appraisee have signed off Form 4/GPSCOT4/PDP, any concerns should be addressed via the appropriate local clinical governance procedures.

If the confidence of the appraisal is to be broken, it is essential that the appraisee is aware that future action will be taken. The appraiser must report any serious concerns promptly to the Clinical Director/AMD who in turn, depending on the seriousness of the concern, would escalate to the RO.

### Information

- **A Guide to Appraisal for Medical Revalidation (CEL 31 (2012))**

### Personal development plan

As an outcome of the appraisal, the appraiser and appraisee should review progress against last year’s personal development plan and identify key development objectives for the year ahead, which relate to the appraisee’s personal and / or professional development. This will include agreed actions.

The actions agreed in the Form 4/GPScot4/PDP are for the appraiser to pursue, and the appraiser has no ongoing responsibility to ensure that actions are followed or resources made available. For consultants that responsibility lies with the medical manager.

### Consultants working in more than one board

Employers must agree on a ‘lead’ employer for the appraisal. Agreement will also include: appropriate discussion prior to the appraisal to ensure key issues are considered, systems for accessing and sharing data, and arrangements for action arising out of the appraisal.
Consultants with honorary university contracts
As recommended by the Follett report, NHS consultants with a substantial role in undergraduate teaching, administrative work or university-led research under an honorary contract with a university should undergo joint appraisal in respect of their complete range of NHS and university duties (either with one appraiser for each component, or a single joint appraiser if properly qualified for this task). As part of the appraisal process, there is a supplementary appraisal form specifically to allow doctors to present information relating to the academic component of their work, which is available in electronic form on the SOAR platform.

Information
- GMC Continuing Professional Development for Doctors
  http://www.gmc-uk.org/education/continuing_professional_development.asp
- GMC Supporting Information for Appraisal and Revalidation
  http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp
- GMC The Good Medical Practice Framework for Appraisal and Revalidation
  http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp
- GMC Guidance on Colleague and Patient Questionnaires
- SOAR website for secondary care doctors
  http://seccare.appraisal.nes.scot.nhs.uk/
- CEL (2012)31: NHS Scotland guide to appraisal for revalidation (July 2012)

Consultant reward schemes

The distinction awards process in Scotland has been frozen since 2010. This freeze was initially imposed as an interim measure pending the publication of the DDRB report into award schemes SCC has continued to call upon the Scottish Government to reinstate higher awards in Scotland as a priority, until an appropriate Scottish way forward has been agreed.

The advice which follows is based on the current schemes and documentation.

Distinction awards
Introduction
The distinction awards system was set up in 1948, following the recommendation of the Spens Committee ‘that there should be established a system of distinction awards which would provide for a significant minority of consultants the opportunity to earn income comparable with the highest which could be earned in other professions’. The distinction awards system has been reviewed and changed a number of times since then.
Scottish Advisory Committee on Distinction Awards (SACDA)

The Scottish Advisory Committee on Distinction Awards (SACDA) acts on behalf of Scottish ministers by taking the final decisions on which NHS consultants will receive awards and reviewing the retention of awards on a regular (five-yearly) basis, using a system based on peer review with employer and lay input and the evidence submitted by consultants in their CV form.

SACDA has 14 members, including the chairman and medical director/vice-chairman. Members are appointed by Scottish ministers in accordance with the Commissioner for Public Appointments in Scotland Code of Practice. It includes applicants sought from the Academy of Medical Royal Colleges and Faculties in Scotland; the SCC as representing the general body of consultants in Scotland; two NHS employers; and two lay members. Members of SACDA are appointed as individuals, not representatives of any specialty or employer. The chief medical officer (CMO) and the chief executive of NHSScotland are ex officio members. The chief dental officer in Scotland and the chairman and medical director of the Advisory Committee on Clinical Excellence Awards for England and Wales are observers ex officio at the final meeting of each awards round.

Value of distinction awards

There are three categories of distinction awards, which are A+, A and B, with A+ being the highest.

Until the awards were frozen, approximately 13-14 per cent of consultants received an award in the course of their career.

Change in circumstances

The following changes in circumstances may affect payment of, or eligibility for, awards. It is the responsibility of both the award holder and NHS employer to inform SACDA of such changes.

Change in nature of contract: where an award holder changes substantially the nature of the contract held with the NHS employer or the number of PAs undertaken, continuation of the award will be subject to review by SACDA.

Change in specialty: if an award holder ceases to practise in the specialty for which the award was granted, the circumstances of the case will be subject to review by SACDA.

Unpaid leave: the payment of an award will cease during any period of unpaid leave. If the leave is for a period in excess of one year, reinstatement of the award will be subject to review by SACDA.

Secondments: if an award holder is seconded full time to a post with a non-NHS employer, they will not be eligible to hold an award. As such, the award will be regarded by SACDA as suspended for the period of their secondment. When the consultant returns to an NHS post, reinstatement of the award will be subject to review by SACDA.

If an award-holding consultant returns to clinical work after a period in a full-time general management position, other than medical director, reinstatement of the award will be subject to review by SACDA.
Prolonged absence from the NHS: if a consultant is absent from NHS service and does not practise within their specialty for more than one year, SACDA will review the award in the light of the circumstances of each case.

Re-employment after retirement – effect on entitlement: Awards cease on retirement and are consolidated into pension. If a consultant who had previously held an award is re-employed, they will not be eligible to receive their award payment.

Criteria
Awards are made on the basis of outstanding contributions over and above what could normally be expected for the individual consultant in their situation in the following areas: professional excellence and leadership; research and service innovation; management, administration and advisory activities; contribution to clinical governance, audit and evidence based medicine; teaching and training; and achievement of service goals.

There is no link between the number or date of receipt of locally awarded discretionary points and eligibility for distinction awards.

There is no lower age limit at which consultants may apply or receive an award. However, they will normally be expected to have 10 years’ experience at consultant grade in their discipline before applying for a B award. Those applying for an A award will normally be expected to have held a B award for 5 years. Those applying for an A+ award will normally be expected to have held an A award for 5 years.

Review of awards
All awards granted from the 1989 awards round onwards are subject to five-yearly review to ensure that each award holder continues to meet the criteria appropriate for a distinction award. However, those consultants who have left the NHS or who declare in writing that they will have done so (for whatever reason) before the fifth anniversary of their award are not subject to review. If an award holder advances to a higher award between two reviews, they will fall into a new five-yearly cycle from the date onwards. SACDA requires a CV form to be submitted and the views of the NHS employer are sought as well as two or more assessor citations.

Although reviews are carried out routinely at five-yearly intervals, SACDA reserves the right to review at any time any case where they have a reservation as to whether the criteria continue to be satisfactorily met or where there is evidence of disciplinary action by the NHS employer, the GMC or GDC or criminal conviction.

If a preliminary decision is taken by SACDA to withdraw or downgrade an award, the consultant’s NHS employer will be informed. The consultant will be advised of the preliminary decision and the reasons for it by the SACDA chairman and a copy of all documentation received for the review will also be sent. They then have the opportunity to put their case, in writing, to SACDA for discussion before a final decision is made by the committee as to whether the award will be continued, downgraded or withdrawn.

Information
- SACDA website
Discretionary points

The consultants’ discretionary points scheme was introduced in April 1996, replacing the old C award element of the distinction awards scheme. All consultants who have reached point five of the pay point scale are eligible for consideration. Distinction award holders are ineligible. Consultants granted discretionary points are not normally considered again for two years, although employers and the profession locally may vary this provision.

The following principles also apply:
- there are no age limits for discretionary points
- locum consultants are not eligible for the payment of points
- clinical academics with honorary consultant contracts are eligible for payment of points and should be considered equally with other consultants
- consultants working for other employers on a service agreement or recharge basis are considered for points by the employer holding the contract, but consultation should take place with the employer providing the service
- consultants jointly contracted to more than one employer (i.e. where there is one contract) are considered under the arrangements agreed between the employers for determining pay and conditions of service matters or any agreed lead employer responsibilities
- consultants employed under separate contracts (i.e. where there is more than one contract) are considered by each employer under each contract.

Salary

Discretionary points are consolidated payments in addition to the consultant’s salary and there are eight points of equal value. Points are paid at the discretion of the employer in the light of advice from the profession locally (subject to the award of a minimum number of points – see below). Discretionary points are pensionable and consultants will retain payment of points granted by one NHS employer on transfer to another NHS employer. Awards for each round are paid from 1 April. There is no review procedure for discretionary points.

Numbers of points

Employers are required to award a minimum of 0.35 points per eligible consultant per year. This is a minimum number and employers may award more. More than one discretionary point at a time may be awarded to individual consultants, subject to the maximum of eight discretionary points in total.

When employers calculate the number of points they are required to award, if a fraction of a point results, this should be rounded up to a whole point. Therefore, individual consultants should only receive whole points and not fractions of points. Where a small number of consultants is employed, employers may be flexible, for example, by aggregating points over two years.

The calculation of the number of eligible consultants is made on the basis of actual numbers rather than whole-time equivalents.
Part-time consultants

Part-time consultants are paid the appropriate proportion of the value of any points awarded.

Criteria

The principles of the nationally agreed criteria are:

- discretionary points are not seniority payments, nor automatic annual increments
- consultants in all specialties and all types of posts are equally eligible
- to warrant payments, consultants are expected to demonstrate an above average contribution in respect of service to patients, teaching, research and the management and development of the service. Contributions to clinical audit, professional and multidisciplinary team working and wider contributions to the work of the NHS nationally should also be considered. Significant contribution towards the achievement of local NHS service priorities, and undertaking recognised significant heavy workload or responsibilities in pursuit of local NHS service goals, are also to be taken into account
- progression at each step up the discretionary points scale should reflect an increasing quality and range of contributions.

There is no nationally agreed procedure for determining how applications for discretionary points should be made and arrangements may vary from employer to employer. Most employers have adopted a procedure following agreement with the LNC.

There is also no nationally agreed mechanism for making decisions about who should receive discretionary points. Ultimately, it is for the employer to decide on awards and the NHS board must also approve the arrangements for deciding payments. However, there should be a mechanism for ensuring professional input and procedures should be determined in consultation with the profession locally and command their confidence.

Appeals

There is no nationally agreed model for an appeals mechanism but employers should have in place a mechanism for appeals about the operation of the system and for overlooked individuals.

### Information

- SEHD Letter to chief executives regarding changes to the discretionary points system, 12 January 2000
- NHS Circular PCS (DD) 1995/6 Consultants’ Discretionary Points
- Both available on the BMA website at http://www.bma.org.uk/sc/employmentandcontracts/doctors_performance/awards/SCCdiscretionarypoints.jsp
Disciplinary procedures and suspension

Consultants facing disciplinary action are advised to seek help from the BMA at the earliest opportunity.

NHS boards, as employers, carry responsibility for investigations into allegations against any of their medical or dental staff and for any subsequent disciplinary processes. They are also responsible for establishing their own local disciplinary procedures for medical and dental staff in respect of personal conduct. In respect of all other aspects of disciplinary procedures, employers must follow the provisions in the relevant NHS circulars issued by the SGHSCD.

Disciplinary procedures cover the following areas:
- personal misconduct
- less serious cases of professional misconduct or incompetence – an intermediate procedure
- serious cases of professional misconduct or incompetence
- appeals, including the right to appeal to Scottish ministers under paragraph 190 for eligible consultants (see below) and the right for a consultant to appeal against the employer’s decision concerning whether a complaint or allegation relates to personal or professional issues.

The definitions to classify conduct are contained in NHS Circular 1990 (PCS) 8 and are as follows.

**Personal conduct**: performance or behaviour of practitioners not associated with the exercise of medical or dental skills.

**Professional conduct**: performance or behaviour of practitioners arising from the exercise of their medical or dental skills.

**Professional competence**: adequacy of performance of practitioners arising related to the exercise of their medical or dental skills and professional judgement.

The procedures set out in the national guidance are covered in the following sections.

**Personal misconduct**

Personal conduct allegations cover offences such as persistent lateness or absenteeism, rudeness to a colleague or, in extreme cases of gross misconduct, theft or violence.

In cases solely involving personal misconduct, the position of a doctor or dentist is no different from that of any other health service staff. Employers should draw up detailed disciplinary procedures covering all their staff that provide mechanisms for investigating alleged offences, disciplinary hearings, a series of warnings short of dismissal, dismissal itself and appeals against proposed action. Each employer’s procedure should define who has the power to issue warnings or to dismiss.

There is an agreed appeal mechanism if a doctor or dentist does not agree with the employer’s decision to treat an allegation as one of personal conduct. The doctor/dentist may appeal within seven days of receipt of the formal notification to a Classification Appeal Committee, which is constituted as follows:
• a chairperson, drawn from an agreed list, who will be a solicitor and not in the employment of the NHS or the Central Legal Office
• a medical director/DPH from another board
• a medically/dentally (as appropriate) qualified professional not employed by the board nominated by the BMA LNC.

The decision reached on the classification is binding on both parties.

Consultants who have the right to an appeal against dismissal to Scottish ministers under paragraph 190 should be aware that this right does not apply to cases of personal misconduct.

Intermediate procedure
Employers should have a procedure to resolve cases of alleged professional misconduct or incompetence where the outcome will fall short of dismissal. Under NHS Circular 1990 (PCS) 8, such a procedure involves an investigation by external clinical assessors. It provides a mechanism to deal with problems at an early stage and could be used either for specific disciplinary allegations, for problems arising from differing professional views or for problems arising because of personality conflicts.

Role of the clinical assessors
The medical director is responsible for appointing external assessors. Under the nationally agreed procedures, these are nominated by the Scottish Joint Consultants Committee (SJCC). The assessors will visit the employer, investigate the problem (including interviewing those involved if necessary) and report to the medical director. They may claim expenses in respect of the visit.

Rights of the consultant
The consultant should be provided with a list of those to be interviewed, given the opportunity to ask for other individuals to be interviewed, provided with copies of written statements and should be able to be accompanied by a friend or representative when interviewed.

Assessors’ report
The assessors are asked to provide a report setting out the findings and facts and making recommendations for action. The consultant should be able to comment on the factual content.
Disciplinary action
The medical director will need to decide what further action is required, which may include periods of retraining, study, or mentoring as well as disciplinary warnings. The employer may want to set up a panel as a result of the report to decide upon disciplinary action.

Appeals
The consultant must have the opportunity to appeal. Since these cases involve matters of professional conduct or competence, the appeal panel should have independent medical representation.

Consultants facing a serious professional misconduct or incompetence procedure should take urgent steps to secure representation from their medical defence organisation.

Serious cases of professional misconduct or incompetence
This type of procedure should be used for handling serious disciplinary matters of a professional nature when the outcome could be dismissal. The procedure involves a panel inquiry where, because of the potentially serious outcome, evidence is likely to be legally tested. The following steps should be followed by the employer.

Preliminary investigation
The medical director should carry out a preliminary inquiry to establish if there is a prima facie case, which could result in serious disciplinary action. This may involve external assessment of the definition of the behaviour which has been called into question.

Doctor informed
The doctor should be informed immediately of the nature of the complaint and be given the opportunity to comment on the case before a decision is taken to proceed.

Decision to proceed
If the decision is to proceed, an investigatory panel will need to be set up to conduct the inquiry. If the facts have already been established in a court of law there is no need for an inquiry. The findings of a government public inquiry may also be sufficient to mean that a further investigation is unnecessary.

Inquiry
The employer should set up a small panel which in most cases will be chaired by a lawyer. There should also be independent professional input. The SJCC is used as a source of advice for choosing professional members as provided under NHS Circular 1990 (PCS) 8. The hearing should be held in private and take the form of a formal examination of the witnesses, with legal representation.

Panel report
The panel report should be in two parts: the factual part and the part containing the panel’s views on whether the doctor was at fault. The second part may also contain recommendations for disciplinary action. The doctor should have the opportunity to comment on the factual content of the report.
NHS board’s decision
The NHS board should be responsible for determining any disciplinary action. The doctor should be informed of the recommendations and be given the opportunity to offer any mitigation.

Time limits
The employer should have time limits in operation for each stage of the case. As provided in NHS Circular 1990 (PCS) 8 the procedure should be completed within 32 weeks.

Appeals
There should be a mechanism for appeals against the decision of the NHS board, whether that decision is dismissal or less serious action. In addition, consultants with protected paragraph 190 appeal rights are eligible to appeal against dismissal to Scottish ministers under paragraph 190 of the TCS (see below).

For non-paragraph 190 appeals, the SCC advises that the employer should set up an appeal panel, normally with a legal chairperson. The NHS board should provide a member of the appeal panel, for example, the board chair or another non-executive director. If a member of the NHS board is on the appeal panel, it is important that they should have been excluded when the board made its original decision on disciplinary action. There should also be external consultant input nominated by the LNC and agreeable to the employer.

Paragraph 190 appeals
A consultant appointed prior to, and whose contract included a right of appeal against dismissal to Scottish ministers under the provisions of paragraph 190 of the pre-2004 contract, continues to benefit from this right of appeal. Other consultants have the right of appeal against dismissal as locally agreed between the employer and the LNC.

To be eligible to appeal, consultants must have been dismissed on the grounds of professional misconduct, professional incompetence, redundancy or some other substantial reason. Consultants dismissed on the sole grounds of personal misconduct are ineligible (although the ground for dismissal can be challenged within a one month timescale under paragraph 190(d)). Consultants who have been summarily dismissed, i.e. dismissed without notice, may not have the right to appeal.

During the course of a paragraph 190 appeal, consultants should remain suspended on full pay. Scottish ministers seek advice from a professional committee which normally interviews the consultant and employer representative(s). There are strict timetables to be observed. These are detailed in paragraph 190.

Information
- TCS, section 10 and appendix 9
- NHS Circular No 1990 (PCS) 8 as amended by 1990 (PCS) 32
Suspension

Occasionally, employers may find it necessary to suspend a consultant from duty in order to assist the process of investigation and/or to protect the interests of patients, the consultant and other staff. In order that clear procedures can be set up locally, employers should take into account the guidance on suspension contained in NHS circular PCS (DD) 1994/11. The guidance includes an indicative timescale. Where suspension is considered, the following principles should apply:

• the employer is required to give serious consideration to alternatives to suspension and it is important to ensure that this has been done
• suspension should not be seen as a punitive measure and is without prejudice to subsequent inquiries
• suspension should always be on full pay
• periods of suspension should be kept as short as possible and every effort made towards early resolution of the case. A review of the position should take place regularly (the circular recommends review on a fortnightly basis) and the consultant kept informed of developments after each review.

As a result of a report from a working group on suspension of medical and dental staff in 1999, additional guidance was developed for employers which includes the following points:

• employers are required to notify the SGHSCD of any suspensions and provide monthly progress reports as well as a final report reviewing the process
• a pool of legally qualified chairs and lay members has been established from which employers can draw to sit on Committees of Inquiry
• dates and timescales for the procedure should be laid down at the preliminary hearing
• NHS boards with honorary contract holders on their staff should have agreed arrangements with the university, as the substantive employer, for disciplining such individuals
• control should be exercised over suspended doctors or dentists working as locums.

Information

• NHS Circular PCS (DD) 1994/11, Disciplinary Procedures for Hospital Medical and Dental and Community Medical Staff
• PCS (DD) 1999/7, Report of the Short Life Working Group on Suspension of Medical and Dental Staff
Consultant appointment procedures

Consultants carry ultimate clinical responsibility for every patient seen under their care. The public is therefore entitled to expect that all consultants will have reached the highest standards of skill and knowledge and this is guaranteed by means of a statutory appointments procedure laid down in regulations. The regulations and supporting guidance were revised in July 2009 (The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009).

While the majority of the actions within the consultant recruitment process, which were previously subject to regulation, now lie with the NHS boards who hold responsibility for the process, some key elements are still subject to regulation and remain under statutory control. The statutory element includes the appointment of a trained External Adviser from a different NHS board as a full member of the consultant assessment panel: this is intended to ensure the clinical quality of appointed candidates is maintained. The External Adviser will have been trained in selection processes and, with experience of other appointments, can provide advice on the appointment from a different perspective than the local clinical team.

Planning and advertising a consultant post

Employers should begin planning for a consultant appointment well before the post is to be filled. They should consider service needs, the amount and level of training that may be required, teaching, supervision of junior staff, continuing professional development, research and any special interests and produce a draft job description and person specification which must be sent to the External Adviser for their advice and comment. They should also identify a lead officer to manage each individual recruitment process.

All potential applicants should be given the job description; the person specification; information from the board with details of arrangements for practice, e.g. units, clinics etc; details of staffing and relevant services covered; where appropriate, information about undergraduate or postgraduate medical/dental teaching; and the relevant TCS including pay. The employer should also ensure that a job plan is available for the consideration of candidates for appointment to a consultant post.

Employers should look to advertise details of vacant posts widely which should normally include a professional journal. The use of the SHoW (Scotland’s Health on the Web) vacancy database is strongly encouraged: it is available online at: http://www.jobs.scot.nhs.uk/

Candidates for consultant posts should always request details of the TCS from the board in advance of the appointments committee. Advice can also be sought from the BMA, and from the LNC, which should have been involved in negotiating any local flexibilities to national agreements.

Eligibility for appointment and specialist register

On successful completion of specialty training, doctors are awarded a certificate of completion of training (CCT), allowing them to practise across Europe as recognised ‘specialists’. The GMC recommends CCT holders for inclusion on the specialist register, which it administers. The specialist register includes the names of all CCT holders together with those of other eligible specialists, and
shows their specialty and, if requested, any particular field of expertise within it. Eligible specialists are defined as:

- European Economic Area nationals holding recognised specialist qualifications
- other overseas nationals holding specialist qualifications that are deemed equivalent to the CCT
- doctors who have followed academic or research training paths, resulting in a level of knowledge and skill consistent with NHS consultant practice in that specialty.

Information
- General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003
- EC Medical Directive 93/16/EEC
- The European Specialist Medical Qualifications Order, Statutory Instrument 1995 No 3208
- GMC: http://www.gmc-uk.org/doctors/before_you_apply/background.asp

From 1 January 1997 it has been a legal requirement for all doctors to be on the GMC's specialist register before they can take up a consultant appointment. (In the case of consultant dental posts, individuals must be a registered dental practitioner or a fully registered medical practitioner). However, trainees may explore the possibility of post-CCT careers as soon as it is apparent that a CCT will be awarded in the near future. Consequently, SpRs/StRs are able to apply for a consultant appointment provided the expected date of award of their CCT (or recognised equivalent, if outside the UK) falls no more than six months after the date of interview for the consultant post. The consultant assessment panel must also be satisfied that the applicant is sufficiently near to the completion of training to enable them to judge the applicant's suitability for a consultant post.

Membership of the assessment panel
The assessment panel is convened by the appointing board to conduct the candidate assessment. This assessment may include profiling, aptitude tests or multi-station interviews. The panel must include at least one consultant from the specialty. Where possible that consultant should be from the employing board. Depending on the nature of the post and the extent of any undergraduate teaching or training duties, the board may include university representation on the assessment panel. While there is no set limit on the size of the panel, under the regulations the panel must as a minimum include a Chair, with delegated authority from the Board, an External Adviser and one other consultant from the specialty.

External Adviser
The regulations require that a single External Adviser is included on the assessment panel for consultant appointments within the NHS in Scotland. The role of the External Adviser is to advise the recruiting board on each stage in the process, including commenting and advising on the job description, person specification, the selection methodology and participating in the selection process. This External Adviser is identified from the list of External Advisers maintained by the Academy of Royal Colleges and Faculties in Scotland, and must be external i.e. not employed by the recruiting board, and must be in the same specialty as the post being appointed to. In rare instances of small specialties it may be necessary to seek an External Adviser from outside Scotland.
All newly appointed External Advisers undergo training before they are included on the adviser list, and if reappointed to the list again, should undergo refresher training.

This training is co-ordinated by NHS Education for Scotland and includes:
- detailed training on equality and diversity issues;
- refreshers on specialty training curricula and assessment methods used;
- updates on selection methodology and tools that have been used successfully;
- the option to shadow an External Adviser and observe the process, although it should be emphasised that observers will play no role in the recruitment process.

**Process**

Under the regulations, recruiting boards will appoint a Chair for the assessment panel. The Chair will hold delegated authority to offer the post on behalf of the board once the panel has considered the candidates.

Boards should draw up a policy on the use of visits as part of the employment process and communicate this policy to all applicants. Visits are intended to inform the applicant regarding the department and the requirements of the post. Depending on the nature of the post the policy on visits should look to offer applicants an opportunity to visit the department and meet with key staff. The option of a visit, and the timing of such a visit, should be determined by the board, and should be made available to all applicants at the same point in the recruitment process.

Once the assessment panel has made a decision on which candidate(s), if any, should be offered the post, the Chair and the HR Department will then take responsibility for offering and contracting with successful candidates. Any candidate wishing to appeal a decision made by the panel should do so through the appointing board.

All members of the assessment panel hold equal responsibility for raising concerns at any stage within the recruitment process with the Chair. In these instances, it is for the Chair to assess these concerns and to determine whether or not to proceed with the recruitment process. If the decision is taken to proceed to appointment, the Chair should note the concerns raised and indicate the basis on which the decision to proceed was taken. If the Chair decides not to proceed, this decision is reported back to the board, outlining the basis on which this decision was taken. It is for the board to decide on next steps and whether to re-run the process.

If any member of the assessment panel has concerns about the appointment made or the conduct of the appointment, they should make their concerns known in writing to the Chair of the recruiting board, and if it is the External Adviser who has concerns, these should also be made known in writing to the Scottish Academy.

**Fees and expenses**

**Applicants:** Doctors who are currently employed under the national TCS (e.g. consultants or SpRs/StRs seeking a first consultant appointment) are entitled to have their expenses reimbursed by the prospective employer at the appropriate rate. This may include pre-interview visits, providing the applicant is subsequently shortlisted.
Members of assessment panels: External Advisers are entitled to a fee and travelling expenses. Consultants are only entitled to a fee if the AAC duty is undertaken outwith agreed PAs.

Information
- TCS, paragraphs 3.1.5, 9.6 and appendix 5 (b)

Private and independent practice
This section sets out the position relating to private practice under national TCS and other national agreements.

Definition of private practice
Private practice is defined for consultants in the TCS as ‘the diagnosis or treatment of patients by private arrangement’. A private patient is defined in the NHS Acts as a patient who gives (or for whom is given) an undertaking to pay charges for accommodation and services.

Code of conduct on private practice
A code of conduct for private practice setting out recommended standards for NHS consultants is included in the TCS. Its aim is to minimise the risk of a conflict of interest arising between a consultant’s private practice and NHS commitments. The code states that consultants should conform to any local policies and procedures for private practice. Consultants are, therefore, advised to contact their LNC for advice on any local arrangements that may apply.

Disclosure of information
The code says that consultants should disclose details of regular private practice commitments, including timing, location and broad type of activity, as part of the job planning process.

Scheduling of work
Programmed NHS commitments should take precedence over private work and private commitments should not be scheduled during times that a consultant is scheduled to be working for the NHS. Private commitments should be rearranged if there is regular disruption to NHS work and private work should not stop a consultant from being able to attend NHS emergencies when on call. However, the code recognises that there will be circumstances when a consultant may need to provide emergency private care when working for the NHS.

Private care in the NHS
With the agreement of the employer, some private work may be undertaken alongside NHS duties provided there is no disruption to NHS services, although private patients should normally be seen separately. Consultants can only see private patients in NHS facilities with the employer’s agreement. The employer can determine the use of staff, facilities and equipment and any relevant charges.
Co-treatment
The code was amended slightly in 2009 as a consequence of the publication of revised guidance on the arrangements for NHS patients receiving private healthcare in addition to NHS care to allow patients to access both NHS and private care for one condition during a single visit to an NHS organisation.

Information to patients
Consultants should not, while on NHS duty, initiate discussion about providing private services to NHS patients.

Change from private to NHS status
The code says that, where a patient chooses to change from private to NHS status, they should not be treated any differently because of their former private status and should join the NHS waiting list at the same point as if the consultation or treatment was an NHS service.

Information
- TCS, appendix 8: Code of Conduct for Private Practice: Recommended Standards for NHS Consultants
- PCS (DD) 2009/1 Changes to consultant contract code of conduct on private practice [http://www.sehd.scot.nhs.uk/pcs/PCS2009(DD)01.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2009(DD)01.pdf)

NHS contractual provisions
NHS work and private practice
In addition to the code of conduct, the TCS also contain contractual provisions dealing with the relationship between NHS and private activity. These state that consultants are free to undertake private practice without requiring the approval of their employer and without impact on their NHS contract, provided that such work is undertaken outside the time agreed in the job plan for PAs. In addition consultants undertaking private practice are obliged to inform their employer in writing.

Information
- TCS, section 6

Extra PAs and pay progression
Under the contract, there is no obligation for consultants to undertake PAs in excess of the standard 10 per week if they want to do private practice as a full-timer. However, one of the criteria for remaining eligible for pay progression is that consultants should accept up to one extra paid PA in the NHS, if offered, before doing private work. The following points should be noted:
  • if consultants are already working 11 PAs as a full-timer, there is no requirement to undertake any more work
  • 11 PAs could be fewer than 44 hours if some work is undertaken in premium time
• a consultant could decline an offer of an extra PA and still work privately, but with risk to NHS pay progression for that year
• any extra PAs offered must be offered equitably between all consultants in that specialty.

Where a consultant intends to work privately, the matter should be discussed with the employer. The employer may then offer the consultant the option of undertaking up to one extra paid PA per week. The consultant may choose either to accept or reject the offer. If rejected, the employer is entitled to withhold pay progression for that year only.

Where possible, the offer of extra PAs should be made at the annual job plan review and should be no less than three months in advance of the start of the proposed extra PAs, or no less than six months in advance where the consultant would need to reschedule external commitments. There is a three-month minimum notice period for termination of the extra PAs on both sides.

Information
• TCS, section 6 and paragraphs 4.4.6-4.4.12

Private practice during sick leave
Consultants should be extremely cautious during sick leave with regard to the other activities they normally carry out. Some employers may regard the undertaking of private practice as a serious disciplinary offence. In certain circumstances, however, employers might allow a consultant to undertake private work, for example to facilitate a gradual return to work; consultants should always check with their employer before undertaking work while on sick leave and should seek advice from BMA advisers.

Private practice in the NHS
Access to private beds
Under the NHS and Community Care Act 1990, NHS boards may make pay beds available to those staff who are entitled to admit their own patients to the hospital for NHS treatment i.e. to the hospital’s consultant staff. They may also offer patients “amenity beds” for which a charge is made, or another category of private bed for which the patient pays but does not make a private arrangement for treatment with a consultant. The consultant cannot charge any fees for either category of bed.

NHS charges for private practice
The Health and Medicines Act 1988 provides for NHS boards to set their own charges on what they consider to be the appropriate commercial basis.

Involvement of other specialties
When patients are admitted privately, the primary consultant should explain to the patient that the professional services of an anaesthetist and the opinion of a pathologist or radiologist may also be required and that fees will be payable for these services. It is essential that colleagues in the diagnostic specialties are properly involved in the treatment of private patients, so that a personal service may be expected.
Problems have arisen in the past over the practice of arranging the investigations of private patients through the NHS rather than privately. This practice developed for the historical reason that, until the contract changed in 1979, most pathologists and radiologists held whole-time contracts and therefore were not entitled to undertake any private practice. However, the guidance set out in the SGHSCD’s Green Book (see below) helped to clarify the position where the general rule is that private patients should remain private throughout the whole treatment episode, although they do have the right to change their status between an NHS and private patient at any stage of their treatment.

Non-consultant medical staff
Training grade and SAS doctors are required to assist the consultants to whom they are responsible with the treatment of their private patients within an NHS hospital in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of hospital treatment including the salaries of nurses and all medical staff other than consultants. Training grade doctors, when on duty, should not be required to leave their main site of employment to attend to private patients, except for agreed training purposes.

Training grade doctors may undertake additional duties outside their contractual hours if they wish, which may include assisting in private cases either in the NHS or in a private hospital. While many consultants will offer training grade doctors payment for such work, training grade doctors should seek advice from a medical defence organisation about the indemnity position for undertaking fee paying work outside the NHS.

Doctors, such as associate specialists, who do not have their own beds, may treat the private patients of a consultant on a private basis, but only by special arrangement when the consultant concerned, the doctor’s supervising consultant and the private patient have agreed. In practice there are difficulties for non-consultant medical staff in establishing their own practices, as private insurance companies providing private medical insurance are unlikely to recognise them, and it may be difficult to obtain practising privileges at a private hospital, as both of these generally require the doctor to be on the specialist register and hold, or have held, a substantive NHS consultant appointment.

Information
- Sections 57 and 58 of the NHS (Scotland) Act 1978 (as amended)
- Schedule 9 of the NHS and Community Care Act 1990
- Management of Private Practice in Health Service Hospitals in Scotland 1987 (The Green Book)
- Health and Medicines Act 1988
- Overseas visitors’ liability to pay charges for NHS care and services http://www.sehd.scot.nhs.uk/mels/CEL2010_09.pdf
- BMA members guidance: Private practice and junior doctors TCS Appendix 8: Code of Conduct for Private Practice: Recommended standards of practice for NHS Consultants
The Green Book

Guidance exists on the management of private practice in the NHS, although having been published in 1987, it is now out of date in many respects. The guidance describes the procedure for authorising pay beds, the application of charges, practical aspects affecting income from private patients and, most importantly, the principles to be followed in conducting private practice in the NHS:

- that the provision of services for private patients does not significantly prejudice non-paying patients
- generally, earlier private consultations should not lead to earlier NHS admission
- common waiting lists should be used for urgent and seriously ill patients
- normally, access to diagnostic and treatment facilities should be governed by clinical considerations
- standards of clinical care and services should be the same for all patients
- single rooms should not be held vacant for potential private use longer than the usual time between NHS patient admissions.

Much of this guidance is confirmed in the code of conduct on private practice contained in the TCS.

Procedures for identifying private patients are described in the Green Book and it is essential that consultants are aware of the procedures adopted in the hospital in which they work. The guidance and code of conduct also stress that it is the responsibility of consultants themselves to ensure that their private patients are identified as such. A private patient officer should be appointed at hospitals where private patients are treated, and, if consultants require advice on the procedure to be adopted, then this officer should be contacted.

Information
- Management of Private Practice in Health Service Hospitals in Scotland (Green Book) 1987

Private prescriptions in the NHS

The Green Book clarifies that patients receiving NHS services should not be charged. The term ‘services’ in the National Health Service (Scotland) Act 1978 generally covers any services and where there is a definition of service(s) it is prefixed, for example, with the word medical or pharmaceutical.

Despite this, patients may receive private prescriptions. In such cases it would be possible for a consultant to charge an NHS patient a fee for issuing a private prescription. However, it is important that the patient understands the reason for the prescription being private and that a consultant should not write a private prescription when the patient is entitled to an NHS one. Private prescriptions can be written for a number of reasons, for example, the prescribing of a drug which has restricted availability because of doubts about clinical efficacy. The consultant may consider that there is a chance the patient could benefit from the medication, but it would not be funded by the NHS. Where a drug is unlicensed the doctor would have to take full clinical and legal responsibility for the prescription.
In cases where a private prescription has been issued, both an employer and a consultant can charge the NHS patient a separate fee, the employer for the cost of the drug prescribed and the consultant for the issuing of the prescription. The Health and Medicines Act 1988 provides for NHS employers to set their own charges for private prescriptions on what they consider to be the appropriate commercial basis.

The writing and issuing of a private prescription to any patient by a consultant does not form a written undertaking that the patient has become a private patient. A consultant cannot write an NHS prescription for a private patient unless it is for a separate condition to that for which the patient was admitted.

**Information**

- Health and Medicines Act 1988

**Medical indemnity and private work**

Consultants should note that the NHS indemnity scheme does not cover private work, either in the NHS or in private hospitals. Consultants should ensure that they have appropriate indemnity with a medical defence body to cover them for private practice. Indemnity for private prescribing will depend on the individual circumstances. Consultants should seek advice from their medical defence organisation.

Appropriate cover can be obtained from one of the following organisations:

- Medical Defence Union: [http://www.the-mdu.com/](http://www.the-mdu.com/)
- Medical and Dental Defence Union of Scotland: [http://www.mddus.com/mddus/home.aspx](http://www.mddus.com/mddus/home.aspx)
- Medical Protection Society: [http://www.medicalprotection.org/uk/](http://www.medicalprotection.org/uk/)

**Private patients: billing arrangements**

Consultants should inform patients of the likely fee that will be charged for their private medical procedure in advance of their treatment. The scope of the fee should be explained in full, including all the planned elements of the expected treatment process. Where patients hold private medical insurance (PMI), consultants should advise patients to check the reimbursement levels that will be available for their procedure. PMI may cover the cost of private treatment in full or in part. Where the treatment is covered in part, the patient should be told that they are responsible for paying the difference between the consultant’s fee and the PMI reimbursement. Consultants should also inform their patients if they know that they are not recognised for reimbursement by the patient’s PMI.

There is increasing pressure in the private healthcare market for consultants to be paid directly by third parties, rather than being paid directly by patients. New billing arrangements that have developed include requirements for consultants to:

- bill Private Medical Insurers (PMIs), rather than billing their patients directly
- work at fee levels set by the private hospital groups, and to be paid directly by the hospital, not the patient
- work as part of a network, where a private medical insurer agrees fees for services directly with hospitals and consultants receive a cut of the package price.
The BMA believes that the involvement of third parties in both setting and controlling fee arrangements undermines the key principle of the independence of consultant practice. It is important that the direct professional and contractual relationship between consultant and private patient is maintained, which can be achieved through the principles of good billing practice. If a consultant hands over the billing arrangement to any third party, they risk losing control of their practice, which has happened to some radiologists and pathologists.

Information
- BMA guidance on good billing practice: a guide for private practitioners

Private medical insurance companies: specialist recognition
A substantial number of individuals who receive private treatment do so as a result of private health insurance schemes. Private medical insurers (PMIs) such as BUPA, AXA PPP, WPA and Norwich Union, will only reimburse their customers (patients) for their specialist’s fees if the consultant has been granted specialist recognition with the insurer. Therefore in order to be able to treat patients holding medical insurance, many doctors choose to apply for specialist recognition. The requirements to obtain specialist recognition vary between the insurers, but most grant recognition to individuals who are on the specialist register and hold, or have held, a substantive NHS consultant appointment. The recognition arrangements of the insurers do differ, however, and some may not require a formal recognition procedure. It is therefore recommended that you contact the health insurers to determine what their recognition criteria are and to decide whether you wish to agree to their individual terms.

Private hospitals and admitting rights
Many consultants in private practice choose to work in a private hospital. Admitting rights at a private hospital are a matter between the consultant and the hospital concerned, and are generally approved through the hospital’s Medical Advisory Committee (MAC). The criteria and conditions under which consultants may be granted authorisation to undertake the treatment of patients in a private hospital are outlined in the hospital’s practising privileges policy. Therefore a licence to use the facilities of a private hospital is known as practising privileges, and consultants are independent contractors of the hospital.

Regulation of independent sector care
Healthcare Improvement Scotland inspects and regulates independent healthcare services to ensure that they comply with standards and regulations, using announced and unannounced inspections. It operates an open and transparent method for inspecting and reporting on its findings, using standardised processes.

Information
- Healthcare Improvement Scotland website:
GMC position on financial and commercial dealings

The GMC’s Good Medical Practice provides the following guidance:

“72. You must be honest and open in any financial arrangements with patients. In particular:

a. you must inform patients about your fees and charges, wherever possible before asking for their consent to treatment
b. you must not exploit patients’ vulnerability or lack of medical knowledge when making charges for treatment or services
c. you must not encourage patients to give, lend or bequeath money or gifts that will directly or indirectly benefit you
d. you must not put pressure on patients or their families to make donations to other people or organisations
e. you must not put pressure on patients to accept private treatment
f. if you charge fees, you must tell patients if any part of the fee goes to another healthcare professional.

73. You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:

a. before taking part in discussions about buying or selling goods or services, you must declare any relevant financial or commercial interest that you or your family might have in the transaction
b. if you manage finances, you must make sure the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances.”

Information
• GMC Good Medical Practice
  http://www.gmc-uk.org/guidance/good_medical_practice.asp

Fees for private medical work

Consultants are free to set their own charges for private medical procedures. Charges should be representative of what is fair remuneration for their services, based on the individual’s circumstances such as experience, effort, skills and resources applied. It should be noted that due to restraints under competition law, the BMA is unable to recommend fee rates for private medical practice.

When consultants treat patients who have private medical insurance, they are not obliged to set their fee based on the level of benefit that the provider offers their customer (the patient). One exception to this is the healthcare insurer AXA PPP who in July 2008 introduced new terms of recognition for approved specialists. These new terms of recognition state that specialists must charge at the rates outlined in the AXA PPP fee schedule.

Fee-paying work

The arrangements under which NHS consultants may carry out fee-paying work under the 2004 contract, such as reports for insurance companies and medico-legal work, are covered in the section on pay. As noted above, the BMA has limited opportunities to recommend fees for such work undertaken by consultants. However, certain organisations set fees for such work and the BMA has also been able to agree fees with other organisations, such as some government
departments. These are set out in the BMA’s fees guidance schedules available from the BMA or via the BMA website.

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<td>• BMA Members fee guidance</td>
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**Medico-legal work**

Medico-legal work is perhaps the most complex area of fee-paying work. Consultants are generally approached to provide medical reports in connection with a legal action and/or attend court to give evidence, which may involve conferences with counsel or other related work.

Medico-legal work counts as fee paying work under the contract and is distinct from private practice. The fees which may be paid will depend on the status of the witness, i.e. whether the consultant is a witness to fact, a professional witness, or an expert witness. There is also a distinction between criminal and civil proceedings. It is important for consultants asked to undertake medico-legal work to be aware of these distinctions and also to agree in writing in advance the nature of the work to be undertaken, the fees for that work (including cancellation fees), and any further commitments that may arise.

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<td>• BMA Fees Guidance Schedule on medico-legal fees in Scotland</td>
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<td>• BMA Members Expert Witness Guidance</td>
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Pensions

Occupational pension schemes
The NHS pension scheme is a statutory scheme, meaning that the rules which govern the scheme are set out by the Government in primary legislation. The scheme is also subject to legislation issued by HM Revenue and Customs and the Department for Work and Pensions. The BMA has a factsheet online providing a broad outline of the scheme. The scheme rules are complicated and frequently change. Where members are uncertain or when urgent decisions have to be made please seek advice from the BMA Pensions Department.

Information
- Planning for retirement: http://bma.org.uk/practical-support-at-work/pensions/planning-for-retirement

NHS Pension
In April 2013 the Public Service Pensions Act came into force bringing major changes to public sector pensions, including the NHS Pension Scheme. For NHS staff it means an increase to the Normal Pension Age, higher contributions and an end to the current final salary scheme. From 1 April 2008 the NHS Pension Scheme (NHSPS) was amended and a new NHSPS created alongside it for new joiners after this date. Current members of the amended NHSPS were given the opportunity to switch to the new NHSPS during the ‘choice exercise’, which commenced in April 2009 in Scotland.

In 2010 the Government set up an ‘Independent Commission into Public Service Pensions’ to review public service pension schemes. The Commission reported in March 2011 making 27 recommendations for changes to public service pension schemes. In December 2011 the Government made a ‘final offer’ in respect of changes to the NHS pension scheme.

The ‘offer’ It means the closure of the current NHS pension scheme from 1 April 2015, and the movement of all contributing members to a new NHS pension scheme where future benefits will be calculated on a Career Average basis. The proposed accrual rate in this new scheme is 1/54th with the normal pension age being linked to state pension age, which is presently age 65 but is scheduled to increase to age 66 between December 2018 and October 2020, and then to age 67 between 2034 and 2036 with a further increase to age 68 scheduled for introduction between 2044 and 2046.

Members who are within 10 years of their normal pension age on 1 April 2012 will be protected from these changes and will be able to continue to accrue benefits in either the 1995 section or the 2008 section of the NHS pension scheme. In the 1995 section a further level of protection is available for members who are aged between age 46 years and 6 months and 49 years and 11 months on 1 April 2012. For doctors with mental health officer status (MHO status) the further level of protection is available for those aged between age 41 years and 6 months and age 44 years and 11 months on 1 April 2012. In the 2008 section this additional protection is available for members who are aged between age 51 years and 6 months and age 54 years and 11 months on 1 April 2012.
The BMA recommends that consultants take financial advice before considering opting out of membership.

Detailed guidance on the new NHSPS can be found on the pension pages of the BMA website: https://bma.org.uk/practical-support-at-work/pensions

**Mental health officer (MHO) status**
Doctors who before 1995 worked for the majority of their employment caring for mentally ill people may qualify for MHO status, which gives enhanced pension benefits in the form of doubled years of service after 20 years as an MHO and retirement at age 55 without actuarial reduction of pension.

### Information
- BMA Members pensions factsheet: Salaried doctors
  https://bma.org.uk/practical-support-at-work/pensions/faq-mho-pension-advice

**Clinical and medical directors**
The pension position will depend upon the terms of the medical or clinical director's contract. If the contract involves extra PAs beyond full time, these will not be pensionable. If the substantive contract is part time (nine PAs or fewer), then the extra PAs will be pensionable up to 10 PAs in total. The medical/clinical director PAs will also be pensionable if they simply replace pensionable clinical PAs. If the contract provides for extra salary to take account of medical/clinical director responsibilities, but the doctor remains full time, then the medical/clinical director income is pensionable.

The amended NHPS pension and lump sum are based on pensionable income paid in the best of the last three years before retirement (see above). In negotiating a medical/clinical director contract, consultants should keep in mind that substantial pension benefits can accrue if medical/clinical director income is pensioned within three years of retirement, but that the contributions will have been wasted if this income finishes more than three years before retirement.

### Information
- BMA Members pensions factsheet: Salaried doctors

**Working in the NHS after retirement**
It is not normally possible to rejoin the amended NHSPS on returning to work after retirement. A break in service needs to be taken before returning to work in the NHS. Consultants who retire at the normal retirement age or who take voluntary early retirement with actuarial reduction or who have used their redundancy payment to fund their accrued benefits will not be subject to any reduction of NHS pension (also known as abatement) on return to work in the NHS. For consultants retiring on health grounds and returning to NHS employment there is the possibility
that some of their pension may be reduced depending on the level of post-retirement NHS earnings and the tier to which they had been allocated.

Information
- BMA Members Planning for Retirement: http://bma.org.uk/practical-support-at-work/pensions/planning-for-retirement#returning%20to%20work

Personal pension plans (PPPs)
Consultants in the amended NHSPS can take out a PPP. Additionally, if the consultant returns to work after retirement, the NHS income is not pensionable in the amended NHSPS and can therefore be pensioned in a PPP.

Further advice
The Scottish Public Pensions Agency (http://www.sppa.gov.uk/) can provide estimates of benefits in advance of retirement and answer enquiries about the NHSPS (the address and phone number are in all BMA pension factsheets). Guidance can also be obtained from the BMA website and the BMA pensions department.

Redundancy
It is still rare for medical staff to be made redundant. Redundancies can arise through a number of reasons including:
- the closure of a hospital, unit, or department within a hospital
- a reduction in the volume of work carried out by a hospital or unit
- a reorganisation within a hospital or unit resulting in the same work being carried out by fewer people, or by those with different experience or skills.

Consultation
When an employer identifies a potential redundancy situation there is a requirement on the employer to consult a recognised trade union representing the staff concerned (in the case of doctors this is almost certain to be the BMA). There is also a requirement to consult with any individuals potentially at risk of redundancy with a view to discussing the options available, such as alternative reorganisation proposals or possible alternative employment elsewhere.

Selection for redundancy
Once a redundancy situation has arisen an employer is required to draw up criteria, which are as objective as possible, to determine which staff should be made redundant. Firstly, an employer has to identify the group of staff from whom redundancies will be selected. This has to be done fairly. For example, if two departments in different hospitals are merging it would not be appropriate to select redundant staff from only one of those departments.
The following factors may be used in making selections for redundancy:

- skills, experience and qualifications
- standards of work performance
- attendance, fitness and health
- disciplinary record
- length of service.

These criteria are usually appropriate in any redundancy situation and must be agreed with the relevant recognised trade union i.e. normally the BMA.

The BMA also believes that when a redundancy situation arises, employers should offer staff the option of voluntary redundancy or voluntary early retirement, although some employers resist this for fear of losing their best staff.

**Alternative employment**

Once an employer has identified staff to be made redundant, the employer is required to take all reasonable steps to find alternative employment for those staff. In reality this is not always easy. If suitable alternative employment is found then consultants may jeopardise their right to a redundancy payment if they unreasonably refuse to accept the offer of suitable alternative employment.

**Appeal against redundancy**

As with all dismissals, consultants should have a right of appeal if they are made redundant. Those consultants who have retained their rights of appeal under paragraph 190 (see section on disciplinary procedures and suspension) can appeal to Scottish ministers against the redundancy decision. Other consultants should be able to use appropriate local employer appeal machinery ensuring that the appeal is heard by individuals not previously involved in the redundancy selection. There may in addition be recourse to an employment tribunal if the process has not been handled fairly.

**The transfer of undertakings regulations**

A redundancy may be associated with the transfer of activity to a different provider of care. It may therefore be covered by the Transfer of Undertakings (Protection of Employment) Regulations 1981 (‘TUPE’). In these circumstances, the Regulations provide that the employer will have to demonstrate an “economic, technical or organisational reason” for the redundancy.

**Redundancy payments**

Redundancy payments are payable to consultants who are made redundant, either in accordance with specific Whitley Council agreements, or local board agreements. Under the GWC agreements (now found at appendix 13 of the TCS), the amount of the redundancy payment is dependent on the consultant’s reckonable service as at the date of termination. The consultant will receive one month’s pay for each complete year of service up to a maximum of 24 years’ reckonable service. The payment is subject to two years’ continuous service with the present or a previous NHS employer.
As an alternative a member who is eligible to retire from the NHS pension scheme (NHSPS) may choose to retire early without any actuarial reduction in their pension as an alternative to receiving the full lump sum payment. The consultant must have two years’ continuous employment and have reached the minimum pension age. The employer will make a payment to the NHSPS to fund this. However, if the payment they are required to make is less than the lump sum payment the consultant would have received, then the consultant is entitled to receive the balance of the lump sum payment.

Consultants will not be eligible for a redundancy payment in the following circumstances:
- they are dismissed for misconduct
- at the date of termination they have obtained suitable alternative employment with another or the same NHS employer
- they unreasonably refuse an offer of suitable alternative employment
- where employment is transferred to another public service employer who is not an NHS employer.

In a redundancy situation, doctors may not be required to work all their notice. They may be able to take the pension from all of their NHS posts, even if PAs at only one particular employer are being made redundant. If pension is taken from all posts the doctor will be unable to continue in the NHSPS.

Organisational change protections
An organisational change policy statement agreed by the Scottish Partnership Forum covers all organisational change in the NHS in and offers useful protections for staff. It covers issues such as the avoidance of compulsory redundancy, consultation and communication with trade unions and professional organisations, no detriment to current TCS (including income and earnings levels), preservation of pension benefits and premature retirement.

Information
- TCS, appendix 13
- GWC Conditions of Service: section 46, Payment of Superannuation and Compensation Benefits on Premature Retirement
- ACAS advice and guidance on redundancy [http://www.acas.org.uk/](http://www.acas.org.uk/)
- NHSScotland Organisational Change Policy Statement
- BMA website: [https://bma.org.uk/practical-support-at-work/redundancy](https://bma.org.uk/practical-support-at-work/redundancy)
European Working Time Directive (EWTD)

All employed doctors are covered by the European Working Time Directive (EWTD), which is legislation designed to protect employees from working excessive hours. The UK version of the EWTD is also known as the Working Time Regulations (WTR). Both terms may be used. Employers are legally bound to implement the directive and can be penalised by the Health and Safety Executive for non-compliance. A collective UK agreement for senior hospital doctors implementing the Directive was negotiated in 1998.

The effect of the Directive is to limit working hours to 48 each week, with provision for compensatory rest periods. In the terms of the Directive, work is defined as ‘working at his employer’s disposal and carrying out his activity or duties’. It must be noted that no suggested or agreed contractual arrangements can override the 48-hour limit; this must be taken into account in the drawing up of job plans. However, individuals do retain the right to opt out of the 48-hour limit.

In order that the legislation could be introduced sensibly, derogations have been applied, the effects of which include that the 48-hour limit is calculated over an averaged reference period of 26 weeks, and that compensatory rest periods can be taken in lieu. It is recommended that in order to calculate entitlements to compensatory rest, doctors use a diary to monitor the total hours worked (including hours worked while on call) over a minimum period of four weeks.

The key aspects of the directive for consultants are:
• a limit of an average of 48 hours worked per week, over a reference period
• a limit of eight hours worked in every 24-hour period for night work
• a weekly rest period of 24 hours every week
• an entitlement to 11 hours consecutive rest per day
• an entitlement to a minimum 20-minute rest break where the working day is longer than six hours
• a requirement on the employer to keep records of hours worked.

The EWTD is currently under review and changes may be made in the coming years. However the current position is that resident on-call time does count as work and the opt-out remains for individuals. Members should check the BMA website for the latest news on how the Directive applies to doctors.

Information

- PCS (DD) 1999/1 Working Time Directive Agreement for Career Grade Doctors
- MEL 1999/1 Working Time Regulations: Implementation in the NHS in Scotland
- BMA guidance [https://bma.org.uk/practical-support-at-work/ewtdp](https://bma.org.uk/practical-support-at-work/ewtdp)
Compensatory rest

The Directive allows employers to exclude the provisions in relation to length of night work, daily rest, weekly rest and rest breaks if compensatory rest is provided. This means that where rest is delayed or interrupted by work, compensatory rest must be granted. However, there is flexibility about how and when compensatory rest is calculated. The entitlement to compensatory rest will be granted by the employer ‘wherever possible’ (Regulation 24, Working Time Regulations 1998).

The BMA’s view is that rest should be taken within a reasonable period and before returning to work. The Jaeger judgment in the European Court of Justice examined the provision of compensatory rest and stated that: ‘equivalent periods of compensatory rest made up of a number of consecutive hours corresponding to the reduction applied and from which the worker must benefit before commencing the following period of work’.

The BMA recommends that local agreements recognise the importance of ensuring rest is taken as soon as possible after a disruption to rest. It is good practice for such compensatory rest to be taken immediately after the end of the working period. A doctor may commence work at a later time on the day following a significant interruption to rest, after notifying the responsible manager where work was to be performed. Any consultant having to take compensatory leave should ensure that colleagues are forewarned in order that appropriate cover arrangements can be arranged if necessary.

The length of the rest period that should be taken is not clearly defined in the directive. In each situation the rest provided should make up for the rest missed; and, under the provisions of the Jaeger ruling, should be taken immediately after the end of the working period. The implications of the Jaeger ruling are that it will not be sufficient to aggregate the rest available to an individual over a period and assume that the minimum requirements have thus been met.

Doctors on part-time contracts are entitled to the same compensatory rest breaks as those doctors on full-time contracts. It is therefore essential that doctors monitor their hours worked and their entitlements to compensatory rest.

The Directive is not aimed at providing extra periods of leave that consultants can accumulate over a period of time; it aims to ensure consultants are not tired when working.
The medical team

**Consultant responsibility**
Only a consultant or a principal in general practice can accept ultimate medical responsibility in NHS units and the development of new working patterns and increased multi-disciplinary working should not alter this basic principle. Consultants must nonetheless work constructively within multi-disciplinary teams and respect the skills and contributions of their colleagues. They should delegate responsibilities (to both medical and non-medically qualified staff) when they believe it is in the best interests of the patient and are sure of the competence of the staff in question. In the case of referral to non-medically qualified health workers, consultants should ensure that such staff are accountable to a statutory regulatory body, and that a medical practitioner retains overall responsibility for the management of the patient.

Access to secondary care provided by consultants has traditionally been through a GP acting in a gatekeeper role, other than in clearly defined circumstances. There are also nurse referrals from community screening programmes or integrated services such as diabetes programmes, where referrals are normally on behalf of the patient's GP and follow agreed protocols. The traditional pattern is increasingly being challenged with further developments such as:
- moves to increase provision in primary care and community settings
- NHS 24
- widened prescribing rights for new groups of health professionals.

In order to ensure the proper continuity of medical responsibility for patients, the preferred referral route remains GP to consultant, or to a consultant-led team. Where a referral comes from a source other than the patient's GP, the GP may be asked whether they agree to the referral and the GP should be informed about advice given or treatment proposed. Where nurse referrals are accepted under local protocols, these protocols should be drawn up with medical input. Guidance about referral is contained in the GMC's *Good medical practice.*

In the day-to-day performance of their duties, consultants take responsibility for their own practice and many fulfill the role of team leader. The clinical team may include a number of other grades of doctor for which the consultant is responsible.

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**Information**
- GMC Good Medical Practice

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**Grades below consultant**
Until the agreement reached between the BMA and employers on the new specialty doctor grade and contract in 2008, there were several grades available for doctors wanting a career below consultant level: associate specialist, staff grade, hospital practitioner and clinical assistant. All of these grades were closed to new entrants from 20 October 2008, although staff already in these grades at that date are entitled to remain in the grade.
**Associate specialist:** appointments established for those doctors committed to a career in the hospital service who had been unable to complete CCT training or who, having completed it, were unable or did not wish to accept the full responsibility of a consultant appointment. Although the grade is closed, a window of opportunity gave eligible doctors a final opportunity to be regraded to this grade and take advantage of new contractual terms introduced in 2008 (the 2008 Associate Specialist contract).

**Specialty doctor:** this new grade established in 2008 replaces the staff and associate specialist (SAS) grades with a single grade. It also subsumes other grades such as clinical medical officer, hospital practitioner and clinical assistant. Specialty doctors will therefore have a wide range of training and experience. New entrants must have a minimum of four years’ postgraduate training and will deliver routine and emergency clinical care under the supervision of a consultant, but with time they will take on more responsibility, with doctors at the top end of the grade resembling the old associate specialist grade, working independently with only indirect supervision. Specialty Doctors are employed on a contract similar to that for consultants in that it is a time-based contract of 10 PAs per week for a full-time doctor.

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**Information**
- BMA Guidance on staff and associate specialist doctors
  [https://bma.org.uk/practical-support-at-work/contracts/sas-contracts](https://bma.org.uk/practical-support-at-work/contracts/sas-contracts)

**Training grades:** The GMC states that all doctors have a professional obligation to contribute to the education and training of other doctors in their team and must make sure that training grades are properly supervised. In addition to these general requirements, consultants may have a formal role in providing clinical or educational supervision for doctors in training.

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**Information**
- Scottish medical training website

**Non-standard grade doctors:** The policy of the SGHSCD is that employers should not appoint to non-standard grades. This policy has not, however, prevented employers from advertising and appointing to posts which have non-standard job titles although the pay and TCS are equivalent to the national terms, for example, senior clinical fellow, research fellow. If employers wish to employ staff on non-standard pay/TCS, they must apply to the SGHSCD for a variation order (to vary from national terms) from Scottish Ministers.
Doctors in management

Introduction
The GMC’s Leadership and management for all doctors (2012) sets out the wider management and leadership responsibilities of all doctors in the workplace, including:
- responsibilities relating to employment issues
- teaching and training
- planning, using and managing resources
- raising and acting on concerns
- helping to develop and improve services.

The guidance came into effect on 12 March 2012 and replaces Management for doctors (2006).

Consultants are expected to play their part in managing their organisations, not least to ensure that medical issues are given proper priority in the employer’s decision making process. NHS boards are required to appoint a medical director to their board. Most have also established a framework of operating divisions with a divisional/associate medical director and a structure of clinical directorates.

The BMA supports medical managers by giving advice on contracts and pay, representing them at work in disciplinary and contractual matters and at UK level via the Committee of Medical Managers.

Pay
Medical managers can be rewarded in a variety of ways for their management work. Board medical directors have nationally agreed pay and conditions of service on the same basis as other board executive directors while clinical directors may be rewarded by PAs (substituting management duties for other work), EPAs or additional responsibility payments.

Guidance on pensions for clinical and medical directors can be found in the Pensions section.

Medical directors
The Committee of Medical Managers has produced guidance on the role of medical directors which gives more details on the areas summarised below. The guidance is on the website: https://bma.org.uk/practical-support-at-work/doctors-as-managers/medical-managers

The areas of responsibility of a medical director can be summarised as being:

**Corporate responsibilities:** giving professional advice; training; business planning; strategic planning; co-trustee of donated funds.

**Professional responsibilities:** recruitment and selection; health, performance and conduct; distinction awards and discretionary points; job plans; continuing professional development; consultant induction; management and development; clinical outcomes; quality and clinical governance.

**Management responsibilities:** risk management; workforce planning; clinical practice development; succession planning; research and development; teaching; external relationships and liaison.

Medical directors must maintain appropriate continuing professional development to ensure smooth transition back to clinical practice on relinquishing the post.
Clinical directorates

Under a system of clinical directorates, management responsibility is decentralised and devolved. The role of clinical directorates within boards may be different and the position of individual clinical directors within the overall management structure may vary from board to board. Clinical directors will normally work closely with a business manager, finance manager and probably a senior nurse manager in a management team. They will often have a range of functions as set out below.

Strategy: Clinical directors have a strategic management role regarding the directorate’s position in relation to other directorates in the board and other organisations such as community health partnerships. The scale of this role is determined locally. It should be supported through the provision of adequate resources.

Budget: The extent to which responsibility for budgetary management is devolved varies significantly. Some clinical directors negotiate and agree the budget in relation to throughput and workload and will be held accountable for control of the budget and potentially for any under or overspending. Others may have little real control of the budget although they will receive regular financial statements.

Clinical governance: Clinical directors are likely to be closely involved in quality assurance initiatives, often leading on clinical audit programmes, risk management and the investigation of clinical incidents. Particularly in bigger boards, clinical directors will often be responsible for initial investigation of any concerns about the health or performance of colleagues in the directorate.

Staff management: Clinical directors negotiate the distribution of work through the directorate via staff job plans; there is usually a responsibility for coordinating annual leave, study leave, cover during leave, on-call rotas, disciplinary procedures, the training of juniors and the management of SAS contracts as appropriate.

Other important points include:
- clinicians and the clinical director have a joint responsibility to ensure that the work of the directorate is successfully carried out
- clinical directors must have the confidence of the consultants within the directorate
- clinical directors who relinquish DCC PAs in order to carry out their managerial duties must seek to ensure that they have the right to have such PAs reinstated when they step down from being clinical director
- clinical directors must be able to call upon support from other services within the board/division when carrying out management functions, and should be given adequate training and secretarial and office support to carry out their job.

Information
- PCS (MD) 2008/1: pay and conditions of service for health board medical directors (including model contract) http://www.sehd.scot.nhs.uk/pcs/PCS2008(MD)01.pdf
General Medical Council (GMC)

Introduction
The GMC is the statutory regulatory body of the medical profession. Its declared purpose is ‘to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine’. To this end, the GMC has powers to permit doctors to practise, and to remove or restrict the right to practise if they fail to meet the standards it has set.

The GMC exercises its powers by determining whether individuals should be registered as doctors in the UK, setting the standards for medical schools and for postgraduate medical education and training in the UK and establishing a framework of standards and ethics embodied in *Good medical practice*. This sets out a doctor’s professional obligations and duties, and advises on standards of good clinical care, professional relationships with colleagues, matters of probity and doctor’s health.

The GMC does not deal with general complaints and can only take action when a doctor’s fitness to practise is called into question. Broadly it can act in the following circumstances:

- when a doctor has been convicted of a criminal offence
- when there is an allegation of serious professional misconduct that is likely to call into question a doctor continuing in medical practice
- when a doctor’s professional performance may be seriously deficient, whether or not it is covered by specific GMC guidance
- when a doctor with health problems continues to practise while unfit.

The GMC’s procedures are only activated when a case is referred to the Council. Convictions of doctors are usually reported directly by the police. Complaints can be made by individual doctors, members of the public, or employing or other public authorities. However, consultants should in most cases bring concerns about colleagues to the attention of their medical director in the first instance. The GMC has produced guidance for doctors and other healthcare professionals on referring a doctor to the GMC which is available on its website. It is a duty of a doctor under *Good medical practice* to explain any concerns about a doctor’s fitness to practise that may be putting patients at risk to an appropriate person from the employing authority, such as the medical director. If there are either no local procedures, or they do not resolve the problem satisfactorily, the concerns should be passed to the GMC. Doctors are advised to discuss any concerns with an impartial colleague or their defence body. The GMC can also give advice and, before a referral is made, any concerns can be discussed with one its caseworkers. It can be contacted on 0161 923 6402 or on [practise@gmc-uk.org](mailto:practise@gmc-uk.org)

The GMC has previously taken action in circumstances where a doctor has:

- made serious or repeated mistakes in diagnosing or treating a patient’s condition
- not examined patients properly or responded to reasonable requests for treatment
- misused information about patients
- treated patients without obtaining their informed consent
- behaved dishonestly in financial matters, with patients or in research
- made sexual advances towards patients
- misused alcohol or drugs.
The GMC can normally only consider complaints within five years of the incidents that are the reason for the complaint.

**Fitness to practise**

GMC procedures are divided into two separate stages: ‘Investigation’ and ‘Adjudication’. In the investigation stage, the GMC investigates cases to assess the need for referral for adjudication. At the end of the investigation by the GMC of allegations against a doctor, the case will be considered by two senior GMC staff known as case examiners (one medical and one non-medical).

They can:
- conclude the case with no further action
- issue a warning (which will be disclosed to a doctor’s employer, where ‘there has been significant departure from ‘good medical practice’ or there is ‘cause for concern following assessment but a restriction on the doctor’s registration is not necessary’
- refer the case to a fitness to practise (FTP) panel
- agree undertakings.

The adjudication stage consists of a hearing of those cases that have been referred to a fitness to practise panel. At any stage of the investigation the GMC may refer the doctor to an Interim Orders Panel (IOP). An IOP can suspend or restrict a doctor’s practice while the investigation continues. Fitness to practise panels hear evidence and decide whether a doctor’s fitness to practise is impaired.

From May 2008, the GMC introduced a provision for the use of the civil standard of proof (the balance of probabilities) at fitness to practise panel hearings when panelists are making decisions on disputed facts. Previously the GMC used the criminal standard of proof (beyond reasonable doubt). The requirement to move to the civil standard of proof was a result of the Shipman inquiry and the Government’s subsequent white paper, *Trust, assurance and safety: the regulation of health professionals in the 21st century*. The balance of probabilities, as applied in the civil standard of proof, means that the panel need only be satisfied that the alleged facts are more likely than not to have happened. The criminal standard of proof of ‘beyond reasonable doubt’ meant that the panel had to be sure that the case was proven.

Panel hearings are the final stage of the GMC’s procedures following a complaint against a doctor. Panels of three to five medical and non-medical members are appointed by the GMC. In addition to the chairman, who is not necessarily medically qualified, there must be at least one medical and one non-medical member on each panel. A legal assessor sits with each panel and advises on points of law and fact.

Once the panel has heard the evidence, it must consider three matters: whether the facts alleged have been found proved; whether, on the basis of the facts found proved, the doctor’s fitness to practise is impaired; and if so, whether any action should be taken against the doctor’s registration. The application of the standard of proof applies only to the first of these questions.

In deciding on the appropriate sanction, which could be from taking no action to erasing the doctor from the Medical Register, the panel must have regard to the Indicative Sanctions Guidance.
Doctors have a right to appeal to the High Court against any decision by a panel to restrict or remove their registration. The Council for Healthcare Regulatory Excellence (CHRE) may also appeal against certain decisions if they consider the decision was too lenient.

The Health and Social Care Act provided for the creation of the Office of the Health Professions Adjudicator (OHPA) to take over the adjudication of fitness to practice cases from the GMC, resulting in the separation of the adjudication of cases from their investigation and prosecution. On 2 December 2010, following a consultation on the future of fitness to practise adjudication, the Government announced its decision to abolish OHPA, with the GMC retaining overall responsibility for adjudication.

The GMC has therefore taken forward a programme of change to create an efficient and modern adjudication function which operates independently from its other work. This separates entirely its investigation activity and the presentation of cases from adjudication by creating a new Medical Practitioners’ Tribunal Service, which aims to reform the way in which it deals with doctors where there are questions about their conduct or ability to treat patients safely.

The Medical Practitioners Tribunal Service is the new adjudication service for UK doctors and runs hearings for doctors whose fitness to practise is called into question. Parliament approved the establishment of the MPTS in 2011 and it was launched in June 2012. MPTS is accountable to Parliament and to the GMC Council for delivery of its objectives. The establishment of the MPTS was set up to:
- provide better separation between the GMC’s complaints and investigation functions and adjudication, and
- to take over responsibility for the day to day management of hearings, panellists and their decisions.
- The MPTS is funded by the GMC but is accountable directly to Parliament.

Further details can be found on the [MPTS](#) website.

**Handling of local concerns**

The Responsible Officer (RO) regulations came into force on 1 January 2011. They require all organisations in England, Wales and Scotland employing doctors to appoint or nominate a ‘responsible officer’ with responsibilities relating to the regulation of doctors. Responsible officers address concerns about doctors, oversee local revalidation processes and are a central point for holding and sharing information on complaints and concerns about doctors. In Scotland the RO for most NHS doctors, including GPs and locums, is the health board medical director. For trainees, it is the RO at NES. Some non-NHS doctors relate to an RO at their faculty/society. The GMC has developed an [online tool](#) to help doctors check their designated body. If, after using the GMC online tool, you remain uncertain about your designated body, please contact the GMC for advice.

**Duties of a doctor registered with the GMC**

*Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.*:
Knowledge, skills and performance
• Make the care of your patient your first concern.
• Provide a good standard of practice and care.
  • Keep your professional knowledge and skills up to date.
  • Recognise and work within the limits of your competence.
Safety and quality
• Take prompt action if you think that patient safety, dignity or comfort is being compromised.
• Protect and promote the health of patients and the public.
Communication, partnership and teamwork
• Treat patients as individuals and respect their dignity.
  • Treat patients politely and considerately.
  • Respect patients’ right to confidentiality.
• Work in partnership with patients.
  • Listen to, and respond to, their concerns and preferences.
  • Give patients the information they want or need in a way they can understand.
  • Respect patients’ right to reach decisions with you about their treatment and care.
  • Support patients in caring for themselves to improve and maintain their health.
  • Work with colleagues in the ways that best serve patients’ interests.
Maintaining trust
• Be honest and open and act with integrity.
• Never discriminate unfairly against patients or colleagues.
• Never abuse your patients’ trust in you or the public’s trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good medical practice
Good medical practice sets out the principles and values on which good medical practice is founded and standards of competence, care and conduct expected of doctors in all aspects of their professional work. Good medical practice sets broad standards on clinical care; teaching, training and appraisal; relationships with patients; dealing with problems in professional practice; working with colleagues; probity and health.

Information
• Good Medical Practice
  http://www.gmc-uk.org/guidance/good_medical_practice.asp

Professional Standards Authority for Health and Social Care
The Professional Standards Authority promotes the health, safety and well-being of users of health and social care services. It oversees statutory bodies that regulate health and social care professionals in the UK. It assesses their performance, conducts audits, scrutinises their decisions and reports to Parliament. It also set standards for organisations holding voluntary registers for health and social care occupations and accredit those that meet them. It was previously known as the Council for Healthcare Regulatory Excellence (CHRE).
Consultants facing the possibility of investigation by the GMC are advised to seek advice initially from their medical defence organisation. Costs of GMC proceedings are not covered under NHS indemnity.

NHS structure
The Scottish Parliament
Full legislative power for health is devolved to the Scottish Parliament. The cabinet secretary for health and wellbeing is accountable to the Scottish Government for all health policies and for the running of NHSScotland. The cabinet secretary is not accountable for professional regulation, abortion and fertilisation issues, genetics, or the control and safety of medicines. The Scottish Parliament Health Committee can call the SGHSCD Chief Executive, and the chairs of all NHS boards, to account.

The Scottish Government Health and Social Care Directorates (SGHSCD)
The SGHSCD is accountable to the Cabinet Secretary for Health and Wellbeing. It determines national objectives and policies for health protection, health improvement and health services, and provides statutory and financial frameworks for NHSScotland. The SGHSCD also sets national priorities and targets for NHSScotland to meet.

The chief medical officer (CMO) for Scotland
The CMO is the Scottish Government’s principal medical adviser, and as such has direct access to ministers. The CMO is also head of the Scottish Medical Civil Service. The post has direct involvement in the development of health policy in, including prevention, health promotion, health protection and harm reduction. The CMO also has lead responsibility for issues such as clinical effectiveness, quality assurance, accreditation and research, and covers the spectrum of health related issues.
NHS boards
There are 11 mainland and three island NHS Boards in Scotland. Boards have the following strategic remit:
• strategy development, including the production of a local health plan
• resource allocation
• implementation of the health plan
• performance management of the local NHS system
• promotion of integrated health and community planning
• regional workforce plans
• operational management through the operating divisions.

It is through the Local Health Plan that NHS boards are expected to fulfil their remit.

Operating divisions
Each NHS board may have a number of operating divisions, which are responsible for operational management. Operating divisions for primary care support general practice in the delivery of services; give strategic direction; and direct service improvement. Operating divisions for secondary are responsible for the running of hospital services.

Area clinical forum
Each NHS board seeks professional advice from the area clinical forum. This consists of the chairs of each of the seven area professional committees representing medical, dental, nursing and midwifery, pharmaceutical, optical, professions allied to medicine and the CHP professional committee. The chair of the area clinical forum is a full member of the NHS board.

Adult Health and Social Care
The Public Bodies (Joint Working) (Scotland) Bill was introduced to Parliament on May 28, 2013. The aims of the Bill are focussed on improving outcomes for people by providing consistency in the quality of services, ensuring people are not unnecessarily delayed in hospital and maintaining independence by creating services that allow people to stay safely at home for longer. The legislation is currently going through the Scottish Parliament.

Information
• Integration of Adult Health and Social Care
  http://www.scotland.gov.uk/Topics/HealthPolicy/Adult-Health-SocialCare-Integration

Managed clinical networks (MCNs)
Managed clinical networks (MCNs) are linked groups of health professionals and organisations from primary, secondary and tertiary care working together in a coordinated manner, unconstrained by professional and NHS board boundaries, to ensure equitable provision of high quality, clinically effective services throughout Scotland. MCNs are seen in, for example, the delivery of cancer services, diabetes and coronary heart disease.
Information

- HDL (2007)21 Strengthening the role of managed clinical networks
- Managed clinical networks website
  http://www.nsd.scot.nhs.uk/services/nmcn/

Special health boards
Healthcare Improvement Scotland (HIS)
HIS formed on 1 April 2011. It was created by the Public Services Reform (Scotland) Act 2010 and marks a change in the way the quality of healthcare across Scotland is supported nationally. Its key responsibility is to help NHSScotland and independent healthcare providers deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise services to provide public assurance about the quality and safety of that care.

Information

- HIS website http://www.healthcareimprovementscotland.org/home.aspx

It is building on work previously done by NHS Quality Improvement Scotland and the Care Commission and its organisation includes:

Scottish Health Council
The Scottish Health Council (SHC) ensures that the views of patients and the public are properly taken into account by health boards. Rather than speak on behalf of patients and the public, it makes sure that they have the chance to give their own views to health boards and that those views are properly taken into account. As well as assessing how health boards are involving patients in decisions about health services, it develops and shares examples of best practice in public involvement, and helps patients to give feedback to health boards about their experiences of services. The SHC is independent from health boards and is able to comment honestly on how well they involve people in decisions about the care and services they receive.

The Scottish Health Council is a committee of Healthcare Improvement Scotland but has a distinct identity. Its national office is based in Glasgow and it has local offices in each of the 14 territorial NHS Boards.

Information

Scottish Intercollegiate Guidelines Network (SIGN)
The Scottish Intercollegiate Guidelines Network (SIGN) develops evidence based clinical practice guidelines for the NHS in Scotland. SIGN guidelines are derived from a systematic review of the scientific literature and are designed as a vehicle for accelerating the translation of new knowledge into action to meet the aim of reducing variations in practice, and improving patient-important outcomes.

SIGN guidelines are developed by multidisciplinary working groups with representation from across Scotland, including healthcare professionals, managers, researchers and patients. The guideline development groups are selected in consultation with the member organisations of SIGN. A national open meeting is held to discuss each SIGN guideline in draft form. The national meetings are widely publicised and are open to all, providing an opportunity for health care professionals, patients, health service managers, and other interested groups to comment on the draft recommendations and to influence the final form of the guideline. All SIGN guidelines are also independently reviewed by specialist referees prior to publication. Three years after publication (or sooner if required) the guideline is formally considered for review and is updated where necessary to take account of newly published evidence.

Information
- http://www.sign.ac.uk/index.html

The Scottish Medicines Consortium (SMC)
The remit of the Scottish Medicines Consortium (SMC) is to provide advice to NHS Boards and their Area Drug and Therapeutics Committees (ADTCs) across Scotland about the clinical and cost-effectiveness of all newly licensed medicines, all new formulations of existing medicines and new indications for established products (licensed from January 2002). This advice is made available as soon as practical after the launch of the product involved.

The remit of SMC excludes the assessment of vaccines, branded generics, non-prescription-only medicines (POMs), blood products, plasma substitutes and diagnostic drugs. The review of device-containing medicines is confined to those licensed as medicines by the MHRA/EMEA.

SMC also has a horizon scanning function, with the aim of improving financial and service planning within NHS Boards through the provision of early intelligence on new medicines in development. An annual ‘Forward Look’ report is sent in strict confidence to key Health Board personnel.

The remit of SMC was expanded from April 2008 to include the work of the Scottish Antimicrobial Prescribing Group. This group aims to co-ordinate and deliver a national framework for antimicrobial stewardship to enhance the quality of prescribing of antimicrobials across all healthcare settings. for healthcare professionals.

SMC is a consortium of stakeholders from ADTCs and representation is derived from ADTCs across NHSScotland. SMC also has two representatives from the Association of British Pharmaceutical Industry (ABPI) on the consortium. Members of the New Drugs Committee, which is a sub...
committee of SMC, are also elected from nominations received from ADTCs. SMSC recognises that not all specialty areas can be represented on the New Drugs Committee or even SMC and has established a network of clinical experts composed of consultant physicians, surgeons, senior specialist pharmacists, general practitioners and other relevant experts nominated by ADTCs.

Scottish Patient Safety Programme (SPSP) The objective of the Scottish Patient Safety Programme (SPSP) is to steadily improve the safety of hospital care across Scotland by using evidence-based tools and techniques to improve the reliability and safety of everyday health care systems and processes. It recognises the complexities involved in delivering modern healthcare has been designed to standardise approaches to care. There is good research to show which interventions make a difference when it comes to protecting patient safety. Key activities are being progressed in 5 key work streams which comprise: acute adult, maternity and children's quality improvement collaborative (incorporating maternity care, paediatric care, neonatal care), mental health, primary care.

Healthcare Environment Inspectorate (HEI) The Healthcare Environment Inspectorate (HEI) was established in April 2009 to undertake at least one announced and one unannounced inspection to all acute hospitals across NHSScotland every three years to check that the HIS standards for Healthcare Associated Infection (HAI) are being met. If it finds problems, it ensures that NHS boards take the action that is needed to reduce the risks of HAI for patients and staff.

NHS Health Scotland NHS Health Scotland is the national agency for improving the health of the population. Its primary focus is to work with local NHS Boards and their health improvement partners during the implementation phases of public health improvement and health inequalities programmes, and other initiatives designed to achieve health outcomes that meet public health HEAT (Health improvement, Efficiency and governance improvements, Access to services and Treatment appropriate to individuals) targets, promote equality and diversity, and address local priorities.
NHS Education for Scotland (NES)
NES is responsible for supporting NHS services delivered to the people of Scotland by developing and delivering education and training for those who work in NHSScotland. A significant proportion of its core business focuses on training the clinical workforce, with the majority of its funding applied to postgraduate training in Medicine and Dentistry. It also prepares professionals for practice in Clinical Psychology, Pharmacy, Optometry and the Healthcare Sciences, and provides education for NHS staff within the Nursing, Midwifery and Allied Health Professions.

The NES Medical Directorate is responsible for the commissioning and delivery of postgraduate medical education in Scotland. The Scottish postgraduate deaneries are an integral part of NES and have operational responsibility for ensuring that all aspects of postgraduate medical education, from Foundation to Specialty Training, are delivered to the highest standards.

Information
- [http://www.nes.scot.nhs.uk/](http://www.nes.scot.nhs.uk/)

The State Hospital
The State Hospital provides assessment, treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting. It is a national service for Scotland and Northern Ireland.

Information
- [http://www.tsh.scot.nhs.uk/](http://www.tsh.scot.nhs.uk/)

Scottish Ambulance Service
The Scottish Ambulance Service serves all of Scotland (divided into five divisions) and provides an emergency service to respond to 999 calls, as well as a patient transport service, taking patients to and from their pre-arranged hospital appointments. There is also an air wing, which uses helicopters and fixed wing aircraft to provide emergency response and hospital transfer for remote areas.

Information

NHS 24
NHS 24 provides comprehensive up-to-date health information and self care advice for people in Scotland. It provides online and telephone advice and plays a key role in helping people who may need to access local NHS board out-of-hours services when GP practices are closed. Its service includes 24-hour access for patients to health advice from trained nurses.

Information
NHS National Waiting Times Centre
The NHS National Waiting Times Centre is an NHS Special Board made up of two distinct parts – the Golden Jubilee National Hospital and the Beardmore Hotel and Conference Centre. Based in Clydebank, near Glasgow, the Golden Jubilee is Scotland’s flagship hospital for reducing patient waiting times, receiving referrals from across the country in the specialties and services it provides. The hospital is home to the West of Scotland Heart and Lung Centre, which provides regional and national services.

Information
- [http://www.nhsgoldenjubilee.co.uk/](http://www.nhsgoldenjubilee.co.uk/)

National Services Scotland
NHS National Services Scotland is a national support organisation providing a range of national and specialist services enabling improvements in Scotland’s health. Its health support services help NHS boards to deliver better services:
- Health Facilities Scotland – delivering technical guidance, support and advice on healthcare buildings and equipment.
- Health Protection Scotland – protecting people from infectious and environmental hazards.
- Information Services Division – statistical information and analysis that helps NHSScotland make the right decisions for patients.
- National Services Division – commissioning specialist services and screening programmes.
- Scottish National Blood Transfusion Service – providing safe, reliable supplies of blood and tissues.

Its business support services provide expert advice and co-ordination to help NHS boards operate more efficiently:
- Central Legal Office – legal advice to NHSScotland.
- Counter Fraud Services – protecting NHSScotland from fraud.
- National Information Systems Group – providing IT services across NHSScotland.
- National Procurement – buying, storing and delivering goods and services.
- Practitioner Services – supporting primary care practitioners.
- Scottish Health Service Centre – supporting networking and learning [http://www.nhsnss.org/](http://www.nhsnss.org/)
NHS complaints procedure

The Patient Rights (Scotland) Act 2011, which received Royal Assent on 31 March 2011, raises the focus of patient rights and responsibilities. It makes provisions, which come into effect on 1 April 2012, for the encouragement of feedback, comments, concerns and complaints about NHS services. The aim is to support the development of a culture that values and listens to the views of patients, carers and service users to help inform and improve the development and delivery of person-centred quality health care.

Secondary legislation has been drafted (and issued under CEL 7 (2012) in relation to the handling of feedback, comments, concerns and complaints, namely the Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012 (“the Complaints Regulations”) and the Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions 2012 (“the Complaints Directions).

Revised good practice guidance for handling and learning from feedback, comments, concerns or complaints has been developed based on a review of the existing NHS Complaints Procedure (2005) Can I Help You? Guidance (see Annex B of Cel 8 (2012).

The Act raises the status and focus of patient rights and, together with supporting legislation, provides for the encouragement of feedback, comment, concerns and complaints on health care services and also clarifies the responsibilities of relevant NHS bodies and their health service providers in Scotland. Important provisions within the legislation which impact on this guidance are:

• Health service providers and relevant NHS bodies now have the same 20 day period to investigate and respond to complaints;
• The establishment of the Patient Advice and Support Service (PASS);
• The requirement on the relevant NHS bodies to appoint a Feedback and Complaints Manager and a Feedback and Complaints Officer;
• The requirement on health service providers to appoint a Feedback and Complaints Officer;
• The requirement for quarterly monitoring of complaints and annual publication of information about feedback, comments, concerns and complaints; and
• The requirement to demonstrate what learning and improvement has taken place as a result of feedback, comments, concerns and complaints.

Information
- Patient Rights (Scotland) Act
  [http://www.scotland.gov.uk/Topics/HealthPolicy/Patients-Rights](http://www.scotland.gov.uk/Topics/HealthPolicy/Patients-Rights)
- CEL 8 (2012)

Role of the Ombudsman

The Scottish Public Services Ombudsman investigates complaints from aggrieved persons who have sustained injustice or hardship as a result of maladministration or service failure by an NHS body and by family health service providers in Scotland. The Ombudsman will generally only consider
complaints which have already been through the relevant authority’s complaints procedure. Complaints to the Ombudsman should generally be made within 12 months of the events giving rise to the complaint, or within 12 months of the complainant becoming aware that there were grounds for complaint. Authorities are expected to publicise the right to complain to the Ombudsman, along with time limits and contact details.

The Public Services Reform (Scotland) Act 201013 (PSR Act) gave the Scottish Public Services Ombudsman (SPSO) the authority to lead the development of simplified and standardised complaints handling procedures across the public sector. A Statement of Complaints Handling Principles was published by SPSO in January 2011 and this guidance reflects those principles. SPSO has also set up an internal unit, the Complaints Standards Authority (CSA), to lead the development of sector specific standardised complaints handling procedures.

The Ombudsman can be contacted as follows:

The Scottish Public Services Ombudsman
4 Melville Street
Edinburgh EH3 7NS
Tel: 0800 377 7330

Email: ask@spso.org.uk
Web: http://www.spso.org.uk/

Monitoring of complaints

NHS boards are expected to monitor how they deal with complaints they receive. Monitoring should include information relating to equality and diversity – relating to the person making the complaint, the person complained against, and the content of the complaint. This information should help boards improve the service they deliver, and to ensure their service is fair for all. A quarterly report should be produced for the board which identifies trends in complaints, the effectiveness of handling local complaints, and what lessons have been learned. NHS boards must include reports on patient feedback and complaints handling in their annual report.

Each relevant NHS body must ensure that the feedback and complaints manager or someone senior acting on his or her behalf is involved in a review of the quarterly reports at least twice a year with a view to identifying areas of concern, agreeing remedial action and improving performance. Where appropriate, the review must also consider any recommendations made by the SPSO in relation to the investigation of NHS complaints.

Relevant NHS bodies must publish anonymous details annually on patient feedback, comments, concerns and complaints which provides evidence that action is or has been taken, where appropriate, to improve services and show where lessons have been learned. The reports must be easily accessible to members of the public and available in alternative formats as requested. These annual reports will build on the complaints data collected each quarter from each NHS body’s own services and those of the health service providers in their respective area.
Relationship between complaints and discipline

The NHS complaints process requires a clear separation of complaints from discipline. Where a decision is made to embark upon a disciplinary investigation, action under the complaints procedure on any matter which is the subject of that investigation must stop. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the complaints procedure. A similar approach is adopted in a case referred to the GMC.

If a complainant asks to be informed of the outcome of the disciplinary investigation, they will generally be given the same information as if the matter had been dealt with under the complaints procedure – what happened, why it happened and what action has been taken to prevent it happening again. They can also be told, in general terms, that disciplinary action may be taken as a result of the complaint.

Information

- Patient Rights (Scotland) Act
  http://www.scotland.gov.uk/Topics/Health/Policy/Patients-Rights
- CEL 8 (2012)

Health and wellbeing

Introduction

The role of the NHS as an employer in maintaining the good health of its doctors and other employees has often been overlooked or downplayed. Doctors and other healthcare professionals are particularly exposed to work-related injury and stress, the impact of which can be dramatic. In extreme cases, health problems can lead to self-harm or suicide or patients being put at risk.

Procedures and legislation are in place, both at a local level and nationally, to prevent ill health where possible, and to assist doctors for whom impaired health has become a source of concern. These are set out below. Advice is also given on dealing with misuse of alcohol and other drugs.

Doctors in hospitals are also particularly exposed to risks arising directly from their working environment. These include exposure to pathogens, blood-borne viruses and other dangerous substances, radiation, and personal violence. Increasingly stress induced by workload or by workplace bullying or harassment is a cause of ill health.

Poor performance for reasons other than ill health is dealt with in the section on disciplinary procedures.
Management responsibilities

All employers have legal obligations under the Health and Safety at Work Act 1974 to protect the health of their employees, contractors and members of the public. This includes dealing with work-related stress or violence in the workplace. All employers should prepare and publish a statement of their safety policy and the arrangements for implementing it. The Management of Health and Safety at Work Regulations 1999 emphasise a risk management approach which requires employers to identify hazards and assess risks, develop appropriate measures to eliminate or minimise risk and record their findings. Consultants should also note that the European Working Time Directive is a health and safety measure.

Concerns about the failure of employers to fulfil their health and safety obligations should be raised with the employer in the first place and, if not resolved, may be reported to the Health and Safety Inspectorate. All employers are required to report serious accidents, incidents or injuries under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

Consultants may have a case for a personal injury claim if their physical or mental health has suffered from adverse working conditions, which their employer knew or ought to have known were potentially harmful and did nothing to alleviate the problem. The NHS injury allowance scheme can also protect income where this is reduced either permanently or temporarily as a direct result of work-related illness or injury. Details of rights and responsibilities under health and safety legislation are available to BMA members from the BMA in the first instance.

Occupational health services

All NHS employers must ensure that their staff have access to comprehensive, competent and confidential occupational health and safety services, including a consultant in occupational health medicine. Where the occupational health team is made up of an occupational health nurse and/or non-consultant occupational health physicians, managers are obliged to ensure that there is access to and advice from a consultant.

Through their occupational health services, NHS employers should protect the health of their staff from physical and environmental health hazards arising from their work or conditions of work; reduce risks at work which lead to ill health, staff absence and accidents, and help management to protect patients, visitors and others from staff who may represent a hazard, such as from infectious disease. The functions of an occupational health service are to advise employees and employers about the interaction between health and work, to maximise the beneficial effects of this interaction and to minimise the adverse effects. It should be noted that occupational health is primarily a preventive and not a treatment service, but much of the output of an effective
occupational health service is directly or indirectly therapeutic to organisations and the individuals employed by them.

### Information

- Safe and Well at Work: Occupational Health and Safety Strategic Framework for NHS Scotland
  [http://www.scotland.gov.uk/Publications/2011/03/17125508/0](http://www.scotland.gov.uk/Publications/2011/03/17125508/0)

### Personal injury claims

Consultants may have a case for a personal injury claim if their physical or mental health has suffered from adverse working conditions, which their employer knew or ought to have known were potentially harmful and did nothing to alleviate the problem. Consultants who feel that a personal injury claim may be justified should contact the BMA in the first instance for advice.

### Work-related stress

The Health and Safety Executive (HSE) has identified work-related stress as a serious and increasing problem and has stated that half a million people in the believe that stress at work has made them ill. While stress itself is hard to identify, the HSE has noted that ‘a convincing body of research shows that there is a clear link between poor work organisation and subsequent ill health’. It has also noted that medical practitioners are among the groups in which high rates of work-related mental illness have been reported.

Useful guidance on work-related stress is available on the HSE website.

### Information

- Health and Safety Executive website
- PIN Guideline: Managing health at work – guideline 1, Dealing positively with stress at work

### Violence against doctors

The British Crime Survey has reported that doctors and nurses are among those most at risk of threats and assaults in the workplace. A 2007 BMA report Violence at work: the experience of UK doctors reported that a third of hospital doctors had experienced some form of violence in the workplace in the previous year and that doctors working in A&E, psychiatry and obstetrics and gynaecology were even more likely to have experienced violence. The report also noted that the under-reporting of incidents was a widespread problem. The paper recommended training for doctors on the management of potentially violent situations, partnerships with other relevant local agencies (such as the police) and raising awareness of patients’ responsibilities and acceptable behaviour.
Doctors are advised and encouraged to report violent incidents and, through their LNC, to ensure that employers put in place protocols for recording such incidents and effective strategies for dealing with the problem. The HSE has also produced guidance on the assessment and management of violence against staff in the healthcare sector.

The Emergency Workers (Scotland) Act 2005 provides protection for emergency workers who have to respond to emergency circumstances in the course of their employment. In April 2008, the Act was extended, providing doctors, nurses and midwives with protection from obstruction or hindrance whenever they are on duty.

The misuse of alcohol and other drugs

The misuse of alcohol and other drugs is a major threat to health, family, livelihood and potentially, in the case of doctors, a threat to patients. Doctors who misuse alcohol are often at the same time involved in misuse of other drugs, and doctors whose primary problem appears to be alcohol may also be misusing hypnotics, anxiolytics, opioids or amphetamines.

Guidance from the GMC in Duties of a doctor is explicit in the responsibility that doctors have to prevent any risk to patients arising from their own ill health or that of their colleagues. There are additional responsibilities under health and safety regulations which impose duties on all individuals regarding their own health and safety and that of their colleagues.

Once in treatment, doctors do remarkably well, and early recognition and treatment considerably increase the chance of successful rehabilitation. To facilitate this, the BMA recommends that every employer must have a well publicised drug and alcohol policy. Such a policy must include an acknowledgement that organisations within the health service exist to provide high standards of healthcare and such high standards should also be available to employees of these organisations. Policies should provide for involvement of occupational health services, appropriate sick leave, access to treatment services and retention of employment when the employee cooperates. Policies should be supportive rather than punitive. Advice on responsibilities for their own health and that of colleagues should be included in any induction programme.
Transmission of infection

Guidance from the SGHSCD in 2007 on Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers clarifies the position on testing for blood-borne viruses for NHS staff. The guidance recommends that, on appointment, all new healthcare workers should have standard healthcare clearance checks. All new workers should have checks for tuberculosis disease/immunity and be offered hepatitis B immunisation, with post-immunisation testing of response and the offer of tests for hepatitis C and HIV. It states that where a new member of staff’s duties include performing exposure-prone procedures (EPPs), additional healthcare clearance should also be obtained before confirmation of an appointment. This includes being non-infective for:

- HIV (antibody negative)
- hepatitis B (surface antigen negative, or if positive e-antigen negative with a viral load of 10 genome equivalents/ml or less; and
- hepatitis C (antibody negative or, if positive, negative for hepatitis C RNA).

The SGHSCD guidance does not recommend mandatory large-scale screening of healthcare workers for blood-borne viruses. It instead recommends that only the following groups of staff should be tested:

- healthcare workers who are new to the NHS
- healthcare workers moving to a post that involves EPPs (where workers have not undertaken EPPs before); and
- returning healthcare workers.

A Tripartite Working Group (TWG) consisting of The UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (UKAP), the Expert Advisory Group on AIDS (EAGA) and the Advisory Group on Hepatitis (AGH) was set up to review BBV policy which currently places restrictions on BBV infected healthcare workers. In April 2011, the TWG published their report on the Management of HIV-infected Healthcare Workers. In 2013 the advice and recommendations of the Tripartite Working Group on the management of HIV positive healthcare workers were accepted. Healthcare staff in England, Wales and Scotland having HIV treatment will be able to take part in all tasks, including surgery and dentistry.
Healthcare associated infection (HAI)

Reducing healthcare associated infections in Scotland is a key priority for the Scottish Government. HAIs are routinely monitored at both national and local level. This includes the number of cases of *Clostridium difficile* infections (CDI) and Staph aureus bacteraemias (MRSA and MSSA) blood stream infections. The Scottish Government chairs the national Healthcare Associated Infection Task Force, which is responsible for coordinating the development and implementation of a national HAI Delivery Plan, as well as providing support and funding to the NHS to prevent and control healthcare associated infections.

**Information**

- SGHSCD website, HAI section
- NES website resources

Sources of professional advice

**BMA Counselling**

BMA Counselling is staffed by professional telephone counsellors 24 hours a day, 7 days a week. All counsellors are members of the British Association for Counselling and Psychotherapy and are bound by strict codes of confidentiality and ethical practice. You can even choose to remain anonymous when you call. Ongoing counselling is available and regular appointments can be arranged. There is no restriction on the number of calls you can make and, having spoken to a counsellor, you can request to speak to that person again.

**Doctor Advisor Service**

The Doctor Advisor service runs alongside BMA Counselling giving doctors and medical students in distress or difficulty the choice of speaking in confidence to another doctor. If you wish to use the service simply call 08459 200 169 and ask to speak to a Doctor Advisor: you will be given the name of a doctor to contact and details of their availability. This is not an emergency service: in such a situation you should obtain appropriate help from either your GP or usual medical advisor.

Doctor Advisors do not provide diagnoses or treatment, although inevitably any interaction will have a therapeutic aspect. As with BMA Counselling, once you have made contact with a particular Doctor Advisor you may contact them as many times as you feel necessary and there is no limit on how long you stay in touch for.

**Issues dealt with include:**
- Stress
- GMC issues
- Alcohol
- Debt
- Bullying
- Relationship issues
- Substance abuse
- Depression

**Information**

- For detailed information and resources covering doctors’ health and well being, including details of support organisations, see:
  [https://bma.org.uk/practical-support-at-work](https://bma.org.uk/practical-support-at-work)
Health and hospital records

Health records
From throughout the the rights of access by living individuals to their health records are as set out in the Data Protection Act 1998, and the Regulations made under that Act.

Subject to a number of exemptions, the Act gives patients a right of access to all computerised and manual records which contain information about their physical or mental health or condition. Access is available to all records whenever they were made, and unlike previous legislation, there are no date restrictions. Records should be communicated to patients in an intelligible form, accompanied where necessary by an explanation of any terms which are unintelligible. Patients are entitled to explanations for the courses of treatment that have been prescribed for them, and are entitled to take various actions where they believe data in records is inaccurate. However, the right of access is not absolute, and, for example, if the information is likely to cause serious harm to the patient or another person, or identifies another person (who is not a health professional involved in the care of the patient), access may be denied to those parts of the record.

The GMC’s advice is that doctors must keep ‘clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decision made, the information given to patients and any drugs or other treatment prescribed’. Records should be legible and factual, and personal views about a patient’s behaviour or temperament should not be included unless these have a potential bearing on treatment.

Doctors should ensure that their manner of keeping records facilitates access by the patient if requested. They should discuss uncertainties of diagnosis or prognosis with the patient at the time of recording information and note such discussions in the record. Doctors may wish to order, flag or highlight their records so as to ensure that should the patient ultimately seek access, it will be straightforward to identify which the patient may see, and those where an exemption to the right of access applies.

The appropriate health professional must be consulted about applications for access. In secondary care, this will normally be the consultant responsible for the clinical care of the patient. Consultants are advised to contact the BMA for guidance on the fee that they may charge for making records available.

It should be noted that the Data Protection Act does not protect consultants against the release of information on clinical performance or complaints. The Data Protection Act is designed ‘to protect the private lives of individuals’. Hence, if a request is received for information to be released relating to an individual’s ‘private life’ (e.g. details of the person’s family life or personal finances) this information is likely to deserve protection under the terms of the Data Protection Act and hence would not normally be disclosed. However, if the information relates to an individual’s ‘non-private’ life, for example if it concerns someone acting in an official or work capacity, this information would normally be disclosed.
Deceased patients
Statutory rights of access to the records of deceased patients are contained within the Access to Health Records Act 1990. Any person with a claim arising from the death of a patient has a right of access to information covered by the Act and directly relevant to that claim.

Access to patient records under the Access to Health Records Act 1990 applies only to records that came into existence on, or after, . Access to information recorded before this date may only be given where this is necessary to make any later part of the records intelligible.

In circumstances where there is no claim, nobody can claim a legal right of access to information about a deceased patient, although doctors may consider disclosure to be justifiable based on the particular circumstances and knowledge of the patient's wishes. As with the Data Protection Act 1998 certain exemptions apply – for example, if the information is likely to cause serious harm to someone, or identifies another person (who is not a health professional involved in the care of the patient), access may be denied to those parts of the record.

Medical reports
Under the Access to Medical Reports Act 1988 individuals have a right to see medical reports written about them, for employment or insurance purposes, by a doctor who they usually see in a 'normal' doctor/patient capacity. This right can be exercised either before or after that report is sent. (A patient who chooses not to see the report before it is sent may apply for a copy of the report within six months of it having been supplied.) The individual patient/client then has the right to signal any disagreement with matters of fact recorded in that report, and to append their disagreement to the report, or to withhold the report wholly, effectively by withdrawing consent to the release of information.

Caldicott guardians
The 1997 Caldicott report made a number of recommendations for regulating the use and transfer of person identifiable information between NHS organisations and between NHS organisations and non-NHS bodies. Central to the recommendations was the appointment in each NHS organisation of a “Guardian” to oversee the arrangements for the use and sharing of patient identifiable information.

Since then developments in information management in NHSScotland have added to the Caldicott role including:
- Data Protection Act 1998
- Human Rights Act 1998
- Freedom of Information (Scotland) Act 2002
- NHSS Code of Practice on Protecting Patient Confidentiality.
- NHSS Information Governance standards 2005
- e-health developments (such as the ECS, SCI Store, SCI DC etc)
Responsibility for ensuring that patient-identifiable information remains confidential is both an organisational and individual one. It is the responsibility of the Caldicott Guardian to facilitate understanding and awareness of that responsibility and to ensure that all such activities within an organisation are lawful.

Information

- Foundation manual for NHSScotland Caldicott Guardians
  http://www.scotland.gov.uk/Publications/2011/01/31115153/0
- The NHSScotland Caldicott Guardian - Principles into Practice web resource – hosted by NHS Education for Scotland

Hospital records

Staff in NHSScotland who provide care or treatment collect data on patients, some of which is collated and stored on the national database. The national database is managed by Information and Statistics Division (ISD), on behalf of NHSScotland. Data is gathered into ‘national data schemes’ on a wide range of topics, including: hospital admissions, cancer registrations and patients on waiting lists.

The use of information about patients is governed by:

- statute law e.g. the Data Protection Act 1998, the Human Rights Act 1998, the Infectious Disease (Notification) Act 1889, Adults with Incapacity (Scotland) Act 2000, the Abortion Act 1967, and many others
- common law in on privacy and confidentiality (which requires either consent or a legal or public interest requirement for disclosure)
- professional standards
- policies and organisational standards of the SGHSCD and NHSScotland.

All NHSScotland employees, students, volunteers and contractors have to comply with the Code of Practice on Protecting Patient Confidentiality, and failure to comply with the code is a disciplinary offence.
Information

- HDL (2001) 1: The use of personal health information, submission of records to information statistics division, disease registers and the Confidentiality and Security Advisory Group for Scotland (CSAGS)
  http://www.sehd.scot.nhs.uk/mels/HDL2001_01.htm
- Code of Practice on Protecting Patient Confidentiality (NHSScotland2012)
- HDL (2003) 37: The Use of Personal Health Information In NHSScotland To Support Patient Care
- Records management: NHS code of practice (Scotland)
- Information Governance site for NHSScotland, hosted by NHS Education for Scotland
  http://www.knowledge.scot.nhs.uk/ig.aspx

Freedom of Information (Scotland) Act 2002
The Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004 set out new legal rights which came into force on 1 January 2005 to see information held by Scottish public authorities or other organisations which provide services for them. This covers any kind of recorded information, despite how old the information is, and includes information recorded on paper, computer files, including emails, video and microfiche. In the NHS, the bodies covered include NHS boards, community health partnerships, hospitals, GPs, dentists, pharmacists, opticians and other health professionals.

The Scottish Information Commissioner promotes observance by public authorities of the Act, by which ‘a person who requests information from a Scottish public authority is entitled to be given it by the authority’. The Act requires that each public authority produces and maintains a publication scheme which details the types of documents produced and held by the organisation and whether they are accessible to the public. Under the Act, an individual is able to make a request in writing to a public body for information. The body must comply with the request within 20 working days. If it fails to comply the Scottish Information Commissioner can be asked to intervene. Non-compliance could ultimately be regarded as contempt of court leading to an unlimited fine or imprisonment.

Information can only be withheld if it falls under one of a series of exemptions listed in the Act. For example, information can be legitimately withheld if it would harm law enforcement processes, or where it would threaten the health or safety of any person. Even where information falls under an exemption, in most cases information must still be released if the public interest in release outweighs that in withholding it.

Information

- The Scottish Information Commissioner’s Office
  http://www.itspublicknowledge.info/home/ScottishInformationCommissioner.asp
- The full text of the Freedom of Information Act (Scotland) Act 2002
The British Medical Association

The BMA is a voluntary association set up in 1832 ‘to promote the medical and allied sciences and for the maintenance of the honour and interests of the medical profession’. It is the professional association of doctors in the and is registered and certified as an independent trade union under employment legislation. The BMA has sole bargaining rights for all NHS doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields. The BMA offers advice to members on contractual and professional matters and provides individual and collective representation at a local level through BMA regional services.

As a spokesperson for the medical profession to the public, the government, employers, MSPs and MPs, and the media, the BMA addresses matters as wide ranging as medical ethics and the state of the NHS.

BMA divisions
The BMA divisions are the local branches of the association, based on geographical areas, and cover all branches of practice. Every UK member of the BMA is automatically a member of a division. Each division should have a chair, secretary and an executive committee including representatives of the branches of practice locally. Professional and administrative support to divisions is provided by BMA regional services.

Medical staff committees (MSCs)
Some hospitals have an MSC (or equivalent) consisting of all senior medical staff, and appropriate representation of the junior staff. MSCs can have a range of functions including nominating members of the local audit, ethics, and drug and therapeutics committees and generally providing professional advice to assist local functions or implement national initiatives.

Local negotiating committees (LNCs)
LNCs consist of local representatives of all grades of doctor employed by an NHS organisation who will meet regularly to identify issues for negotiation with local management. They will meet with management representatives in a joint negotiating committee in order to conclude, and monitor the application of, local agreements and agree and monitor arrangements for the implementation of national agreements within the organisation. Professional and administrative support to LNCs is provided by BMA regional services.

Area consultants committees (ACCs)
The ACCs are the representative bodies for consultants in their NHS board area. They are the route by which consultants are currently represented at the BMA’s SCC and are one of the routes through which the SCC communicates to consultants. In the 14 Scottish NHS geographical board areas there are 11 ACCs. The Grampian ACC covers Grampian, Orkney and Shetland NHS Board areas, and the and Western Isles ACC is responsible for both these areas. The ACC is the link in the chain between grass-roots consultant opinion at individual employer level and the SCC at Scottish level. It is the forum for local consultant problems and for local consideration of national issues referred from the SCC. Professional and administrative support to all BMA local committees, including ACCs, is provided by BMA regional services.
Scottish consultants committee (SCC)
The SCC represents NHS consultants in Scotland, irrespective of BMA membership, and has full delegated authority to negotiate on devolved matters for those it represents. It also develops policy and responds to consultation documents produced by the Scottish Government and other bodies on behalf of NHS consultants. Its membership is drawn from a wide range of its constituents across Scotland

Consultants Committee (CC)
The CCC represents all consultants in the UK except those working in public and community health. It has sole negotiating rights with the Department of Health for consultants employed under national agreements in England, and conducts negotiations with the employers’ organisation in England, NHS Employers. UK negotiations are conducted through the JNC(S) on which the SCC and the Scottish Government and NHSScotland Employers are represented. The CC also acts on a UK basis on issues which are reserved to the Westminster Parliament.

UK Consultants conference
The UK consultants conference consists of representatives from each medical staff committee (or LNC where there is no MSC) in the UK, along with members of the CC. It debates motions presented to it which then guide the CC’s work in the following year.

Scottish Council
The Scottish Council of the BMA is a standing committee of the BMA and has full delegated authority to consider all matters specially concerning Scotland and, in conformity with the decisions of the representative body, deal with all such matters. It includes dedicated seats for consultants, general practitioners, junior doctors, academic medicine, staff and associate specialists, medical students and retired doctors. Members are elected for three years.

BMA council (UK)
The council is the central executive of the BMA and its Board of Directors under company law. It is responsible for administering the affairs of the association subject to the decisions of representative meetings. It has powers, in the interval between successive meetings of the representative body, to formulate and implement policies on any matter affecting the association.

Consultants are represented on council by at least four and not more than 12 voting members plus the Chair of the CC if/she is not a voting member of Council. Council members are elected from a single UK constituency. Half of BMA Council is elected biennially by postal ballot of the membership of the BMA.

Annual representative meeting (ARM)
The ARM determines the policy of the BMA. The representatives are either elected by the BMA divisions or are appointed by branch of practice committees. It meets annually for four days in June or July.

Scottish Joint Medical Consultative Committee (SJCC)
The SJCC was set up in 1949, by the royal colleges in and the BMA, as a committee able to provide top-level advice to the Scottish Office on behalf of consultants. It considers all matters of policy relating to hospital and public health medicine practice in (excluding negotiations over...
remuneration or terms of service), and formulates such policy where appropriate. The SJCC discusses any such matters with the CMO for Scotland, the SGHSCD and other appropriate bodies. Membership includes representatives from the Academy of Royal Colleges and Faculties in and BMA Scotland.

**BMA advice and support**

The BMA Scotland branch of practice committees are supported by a professional secretariat based in the BMA Scotland office in Edinburgh. Each of the branch of practice committees and conferences as well as the ARM are supported by a professional secretariat based in BMA House in . The BMA also has a number of regional centres staffed by secretaries, employment advisers and industrial relations officers/assistant secretaries, who provide support to regional and local committees and help and advise in disputes or negotiations with employers. The first point of contact for all individual queries are our advisers on 0300 123 123 3 or email support@bma.org.uk. The BMA can also provide specialist advice through its board of medical education, medical ethics committee and board of science.

All these committees and the branches of practice are also assisted by the BMA’s public affairs division, including its parliamentary unit. The BMA Scotland public affairs office promotes the work of the association and the wider medical profession to the Scottish media. It generates positive news coverage and promotes BMA activities and events and the work of individual doctors and medical teams. The public affairs team offers media training to members who have agreed to act as spokespeople, whether as members of national committees such as SCC or as locally elected honorary public affairs secretaries for the BMA divisions. Individual members of the BMA who are interested in receiving media training or who would like support in dealing with media enquiries can seek help from the public affairs office at any time by calling 0131 247 3050.

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**Information**

- Benefits for BMA members
  [https://bma.org.uk/membership](https://bma.org.uk/membership)
- How the BMA’s committees and boards represent doctors
Acronyms

ACAS  Advisory Conciliation and Arbitration Service
ACC  Area Consultants Committee
AVC  Additional Voluntary Contribution
CC  Consultants Committee
CCT  Certificate of Completion of Training
CEL  Chief Executive Letter
CHP  Community Health Partnership
CMO  Chief Medical Officer
CNORIS  Clinical Negligence and Other Risks Indemnity Scheme
CPD  Continuing Professional Development
CPHM  Consultant in Public Health Medicine
DA  Distinction Award
DCC  Direct Clinical Care
DDRB  Doctors and Dentists Review Body
DH  Department of Health
DP  Discretionary Point
DPH  Director of Public Health
EC  European Commission
EPP  Exposure Prone Procedure
EWTD  European Working Time Directive
FSAVC  Free Standing Additional Voluntary Contribution
GDC  General Dental Council
GMC  General Medical Council
GP  General Practitioner
GWC  General Whitley Council
HAI  Healthcare Associated Infection
HIV  Human Immunodeficiency Virus
HMRC  HM Revenue and Customs
HSE  Health and Safety Executive
JNC(S)  Joint Negotiating Committee (Seniors)
LNC  Local Negotiating Committee
MAC  Medical Advisory Committee
MCN  Managed Clinical Network
MHO  Mental Health Officer
MRC  Medical Research Council
MSC  Medical Staff Committee
NHS  National Health Service
NHSPS  National Health Service Pension Scheme
PA  Programmed Activity
PCS  Pay and Conditions of Service Circular
PIN  Partnership Information Network
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<tr>
<td>PPP</td>
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<tr>
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<td>Scottish Advisory Committee on Distinction Awards</td>
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<tr>
<td>SAS</td>
<td>Staff and Associate Specialist Grades</td>
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<td>SGHSCD</td>
<td>Scottish Government Health &amp; Social Care Directorates</td>
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<td>SCC</td>
<td>Scottish Consultants Committee</td>
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<td>Scottish Joint Medical Consultative Committee</td>
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<td>Supporting Professional Activity</td>
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<td>Scottish Public Pensions Agency</td>
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